

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08892

## CERTIFICATE OF DEATH

Reg. Dist. No. 08903  
302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Penna.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. Co. Hospital</b>				d. STREET ADDRESS <b>252 Liberty Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Ippolito</b> Middle <b>Alitto</b> Last				4. DATE OF DEATH Month <b>Aug.</b> Day <b>27</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 14, 1872</b>	9. AGE (In years lost birthday) <b>85 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>13</b>	IF UNDER 24 HRS. Hours <b>13</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Storekeeper</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Castiglione Cosentino</b>		
13. FATHER'S NAME <b>Salvatore Alito</b>			14. MOTHER'S MAIDEN NAME <b>Marie Barbuslio</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Agustalitto Alitto</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 1/2 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Harrisburg, Pa.</b>	(County) (State)	
21. I certify that I attended the deceased from <b>8-23</b> , 19 <b>57</b> , to <b>8-27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>8-27-57</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>J. E. W. Dethlefs</b> M.D. <b>J. E. W. Dethlefs</b> <b>8-27-57</b> PHYSICIAN'S NAME (Type) <b>J. E. W. Dethlefs</b> <b>8-27-57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-30-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Harrisburg, Pa.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Poyser</b>			ADDRESS <b>Hagerstown Maryland</b>		24a. REC'D BY REGISTRAR <b>Aug 28, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Charles H. Powers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CERTIFICATE NO.		REGISTERED	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JUDGE	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CERTIFICATE NO.		REGISTERED	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JUDGE	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

RECEIVED  
AUG 30 1957  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08904

08893

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN lb -			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Emergency Room - Hopsital</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> 1526-2			
d. STREET ADDRESS <b>1108 Old Dover Way</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Carleton</b> Last <b>Baer</b>				4. DATE OF DEATH Month <b>August</b> Day <b>8</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1924</b>		9. AGE (In years last birthday) <b>33</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nat'l Cash Register</b>		11. BIRTHPLACE (State or foreign country) <b>Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Donnie T. Baer</b>				14. MOTHER'S MAIDEN NAME <b>Kathryn Rae Baer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>191-18-9599</b>		17. INFORMANT <b>Joseph R. Baer-</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon- Monoxide Poisoning</b> <b>973.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Connected hose from exhaust into automobile</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>3:00 xxx Aug. 8 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Rural- Hagerstown Wash Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/10/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Uniontown Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Uniontown Fayette Co Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>Aug. 12, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Brown</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		45		JAN 15 1910	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1108 E. COVER RD.		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE	
JAN 15 1957		HOME		10:30 AM		98.6	
SIGNATURE OF EXAMINER		TITLE		SIGNATURE OF WITNESS		TITLE	
JAMES H. HARRIS		LABORER		JAMES H. HARRIS		LABORER	

BUREAU V. 1

JAN 14 1957

RECEIVED



08942

## CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>7 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagers town</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				d. STREET ADDRESS <u>Hotel</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nancy</u> First Middle Last <u>Boyle</u>				4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 24, 1870</u>		9. AGE (In years, last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>3</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James William Findlay</u>				14. MOTHER'S MAIDEN NAME <u>Roberta Carter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Mrs. Nancy Knowles - 200 E. 66<sup>th</sup> St. N.Y. N.Y.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 5</u> , 19 <u>54</u> , to <u>Aug 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 27</u> , 19 <u>57</u> , and that death occurred at <u>12:30 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>28 W. Patomas Street Williamsport, Md.</u> DATE SIGNED <u>29 Aug 57</u>							
ACTUAL SIGNATURE <u>Paul Haak</u>				PHYSICIAN'S NAME (Type) <u>PAUL HAAS, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hiverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Williamsport, Md</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u>Aug 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>E Lee McElroy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. S.

AUG 30 1957

RECEIVED

08943

CERTIFICATE OF DEATH

08946/1

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Waynesboro.</u> 75 X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro.</u> 75 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		d. STREET ADDRESS <u>119 West 3rd St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Franklin</u> Last <u>Burger</u>		4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Peene R.R.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ASSISTANT MGR. FREIGHT OFFICE.</u>	
11. BIRTHPLACE (State or foreign country) <u>Quincy, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gideon Burger</u>		14. MOTHER'S MAIDEN NAME <u>Lavina Manges</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Paul W. Burger</u> Address <u>119 W. 3rd St. Waynesboro, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>6 months</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 27, 1957</u> , to <u>Aug. 31, 1957</u> , that I last saw the deceased alive on <u>Aug. 31, 1957</u> , and that death occurred at <u>7:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>28 W. Tatornae Str. 31 Aug 57</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Paul H. Hak</u> M.D.		PHYSICIAN'S NAME (Type) <u>PAUL H. HAK, M.D. Williamsport, Pa.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/4/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PRICES CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WAYNESBORO R.D. 2, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Shore</u> ADDRESS <u>Waynesboro, Pa.</u>		24a. REC'D BY REGISTRAR <u>Sept. 1957</u> 24b. REGISTRAR'S SIGNATURE <u>C. Lee McElroy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13.5 - 14.1

1890

1952/2/20

3099

Grumpy

Verbleef in de maand 1900

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08894

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08907

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>at home 128 S. Potomac Street</b>				d. STREET ADDRESS <b>128 S. Potomac Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Augustus</b> Last <b>Burger</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 18, 1884</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Office Worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Secretary Woodmen of World</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Augustus Burger</b>				14. MOTHER'S MAIDEN NAME <b>Mrs. Henrietta Rider</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-7188</b>		17. INFORMANT Address <b>Mrs. Anna B. Burger, 128 S. Potomac St City</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b> EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>Aug. 30 '57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-3-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Wash., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. T. Norment</b>				ADDRESS <b>Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR <b>3.1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Blair H. Bowers</b>			



SEP 5 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
08895 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08908

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1 hr.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>On Key St.</b>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (28) 0352.2</b> d. STREET ADDRESS <b>401 Overbrook Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROBERT JACOB CANFIELD</b>			4. DATE OF DEATH Month Day Year <b>August 13 1957 19</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan'y 18 1918</b>	9. AGE (In years last birthday) <b>39</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <b>39</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Glenn Martin Co</b>		11. BIRTHPLACE (State or foreign country) <b>Montanna</b>	
13. FATHER'S NAME <b>Robert W. Canfield</b>			14. MOTHER'S MAIDEN NAME <b>Florence Hiatt</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.2</b>		17. INFORMANT <b>Mrs Lili Canfield</b> Address <b>401 Overbrook Rd Baltimore Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>976X</b> DUE TO <b>Gun shot wound thru heart, hemorrhage &amp; shock</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>shot self thru heart with 22 calibre revolver</b>			
20c. TIME OF INJURY Month, Day, Year <b>8 a.m. 8-13-57</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hagerstown</b>	
20f. (City or town) <b>Wash.</b>		20g. (County) <b>Md.</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>Aug-14-57</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/14/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Deposit Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Deposit Broome Co New York</b>		22e. (State) <b>New York</b>		22f. (Country) <b>USA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>			23b. ADDRESS <b>Hagerstown Md.</b>		
24a. REC'D BY REGISTRAR <b>Aug. 16-57</b>			24b. REGISTRAR'S SIGNATURE <b>Frank J. Rogers</b>		

STATE OF CALIFORNIA  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES EARL RAY		35		Male		White		May 24, 1968	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1125 S. Main St., Memphis, Tenn.		Attorney at Law		Suicide		Homicide		Memphis, Tenn.	
FATHER		MOTHER		SIBLINGS		EDUCATION		RELIGION	
James Earl Ray, Sr.		Lillian Jean Ray		None		High School		Methodist	
PREVIOUS ILLNESS		TREATMENT		HISTORY OF DRUGS		HISTORY OF ALCOHOL		HISTORY OF MENTAL ILLNESS	
None		None		None		None		None	
PHYSICIAN'S SIGNATURE		MEDICAL EXAMINER'S SIGNATURE		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY AND COUNTY	
[Signature]		[Signature]		May 24, 1968		Memphis, Tenn.		Memphis, Tenn.	

BUREAU V. 5

AUG 19 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film C221 10-16-57 et

08944

CERTIFICATE OF DEATH

08909

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, MD</u>		c. LENGTH OF STAY IN TB <u>life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x 27 Hagerstown</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>" "</u>	
d. STREET ADDRESS <u>R #3 Hagerstown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Twin I</u> First <u>not</u> Middle <u>named</u> Last <u>Chaney</u>		4. DATE OF DEATH Month <u>aug.</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-57</u>
9. AGE (In years last birthday) <u>5</u> yrs. <u>14</u> Months <u>5</u> Days <u>14</u> Hours <u>7</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Harry Chaney</u>	
14. MOTHER'S MAIDEN NAME <u>Christina Staley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 5 1/2 MO DUE TO <u>7747</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 HR</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Shops</u> , 19 <u>19</u> , to <u>Shops</u> , 19 <u>19</u> , that I last saw the deceased alive on <u>Shops</u> , 19 <u>19</u> , and that death occurred at <u>Shops</u> , 19 <u>19</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Chas E. Young</u> M.D.		DATE SIGNED <u>williamsport, MD 8/23/57</u>	
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify)	
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>9/3/57</u>		24b. REGISTRAR'S SIGNATURE <u>Chas Bowers</u>	

1100330XV6

# MARIANO STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

## CERTIFICATE OF DEATH

PLACE OF DEATH HOME		PLACE OF BIRTH HOME	
NAME OF DECEASED MARIANO		SEX MALE	
DATE OF DEATH SEP 4 1957		TIME OF DEATH 10:00 AM	
AGE 34		RACE WHITE	
SEX MALE		COLOR WHITE	
OCCUPATION LABORER		MARITAL STATUS SINGLE	
PLACE OF BIRTH NEW YORK		DATE OF BIRTH SEP 10 1923	
NAME OF DECEASED MARIANO		SEX MALE	
DATE OF DEATH SEP 4 1957		TIME OF DEATH 10:00 AM	
AGE 34		RACE WHITE	
SEX MALE		COLOR WHITE	
OCCUPATION LABORER		MARITAL STATUS SINGLE	
PLACE OF BIRTH NEW YORK		DATE OF BIRTH SEP 10 1923	

BUREAU V. 3

SEP 4 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 & Block 22 Film G221 10-16-57 et

## CERTIFICATE OF DEATH

08896

Reg. Dist. No.

08910  
202

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Twin II Noris</u> First Middle Last <u>marie chanev</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-21-57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>5-14</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>14</u> Hours <u></u> Min. <u></u>	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Harry Chanev</u>				14. MOTHER'S MAIDEN NAME <u>Christina Slaley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 5 1/2 MO DUE TO <u>7742</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>6 HRS.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/20/57</u> to <u>8/21/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/21/57</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown, Maryland</u> DATE SIGNED <u>8/23/57</u>							
ACTUAL SIGNATURE <u>Ralph E. Young</u>				PHYSICIAN'S NAME (Type) <u>William Spaulding</u>			
22a. BURIAL, CREMATION REMOVAL (Specify) <u>?</u>		22b. DATE THEREOF <u>?</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hospital disposal</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE <u>9/3/57</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. Bowers</u>	

2281330XVO

BUREAU V. 5

SEP 7 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08897

CERTIFICATE OF DEATH

08911

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Dist. of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Maryland</b>				c. LENGTH OF STAY IN lb <b>1 day</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <b>Washington D. C. 47X-3</b>				d. STREET ADDRESS <b>1815 17 th St. N. W.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EDNA</b> Middle <b>ALICE</b> Last <b>COLLIER</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>26</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 1 1914</b>		9. AGE (In years last birthday) yrs. <b>42</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>11</b> Days <b>25</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Court Reporter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov. Dept. Of Labor</b>		11. BIRTHPLACE (State or foreign country) <b>Stoneham Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>Joseph Collier</b>				14. MOTHER'S MAIDEN NAME <b>Ada Rose Brock</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217 10 3040</b>		17. INFORMANT <b>Mrs. James Sachs Funkstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute lobar pneumonia</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Circulatory failure (shock)</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/24, 1957</b> , to <b>8/26, 1957</b> , that I last saw the deceased alive on <b>8/26 1957</b> , and that death occurred at <b>8:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John H. Hornbaker</b> M.D.				ADDRESS (Street, city or town, state) <b>154 West Washington St.,</b> DATE SIGNED <b>8:28:57</b>			
PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>				<b>Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 30-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Leaf Williamsport, Md</b>				24a. REC'D BY REGISTRAR <b>Aug. 30, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES M. HARRIS		2. SEX Male	
3. DATE OF BIRTH 1912 12 12		4. PLACE OF BIRTH BALTIMORE, MARYLAND	
5. OCCUPATION LABORER		6. CAUSE OF DEATH HEART DISEASE	
7. DATE OF DEATH 1957 12 12		8. PLACE OF DEATH HOME	
9. SIGNATURE OF PHYSICIAN J. M. HARRIS		10. SIGNATURE OF DECEASED JAMES M. HARRIS	
11. SIGNATURE OF WITNESSES J. M. HARRIS		12. SIGNATURE OF DECEASED JAMES M. HARRIS	
13. SIGNATURE OF DECEASED JAMES M. HARRIS		14. SIGNATURE OF DECEASED JAMES M. HARRIS	
15. SIGNATURE OF DECEASED JAMES M. HARRIS		16. SIGNATURE OF DECEASED JAMES M. HARRIS	
17. SIGNATURE OF DECEASED JAMES M. HARRIS		18. SIGNATURE OF DECEASED JAMES M. HARRIS	
19. SIGNATURE OF DECEASED JAMES M. HARRIS		20. SIGNATURE OF DECEASED JAMES M. HARRIS	
21. SIGNATURE OF DECEASED JAMES M. HARRIS		22. SIGNATURE OF DECEASED JAMES M. HARRIS	
23. SIGNATURE OF DECEASED JAMES M. HARRIS		24. SIGNATURE OF DECEASED JAMES M. HARRIS	
25. SIGNATURE OF DECEASED JAMES M. HARRIS		26. SIGNATURE OF DECEASED JAMES M. HARRIS	
27. SIGNATURE OF DECEASED JAMES M. HARRIS		28. SIGNATURE OF DECEASED JAMES M. HARRIS	
29. SIGNATURE OF DECEASED JAMES M. HARRIS		30. SIGNATURE OF DECEASED JAMES M. HARRIS	
31. SIGNATURE OF DECEASED JAMES M. HARRIS		32. SIGNATURE OF DECEASED JAMES M. HARRIS	
33. SIGNATURE OF DECEASED JAMES M. HARRIS		34. SIGNATURE OF DECEASED JAMES M. HARRIS	
35. SIGNATURE OF DECEASED JAMES M. HARRIS		36. SIGNATURE OF DECEASED JAMES M. HARRIS	
37. SIGNATURE OF DECEASED JAMES M. HARRIS		38. SIGNATURE OF DECEASED JAMES M. HARRIS	
39. SIGNATURE OF DECEASED JAMES M. HARRIS		40. SIGNATURE OF DECEASED JAMES M. HARRIS	
41. SIGNATURE OF DECEASED JAMES M. HARRIS		42. SIGNATURE OF DECEASED JAMES M. HARRIS	
43. SIGNATURE OF DECEASED JAMES M. HARRIS		44. SIGNATURE OF DECEASED JAMES M. HARRIS	
45. SIGNATURE OF DECEASED JAMES M. HARRIS		46. SIGNATURE OF DECEASED JAMES M. HARRIS	
47. SIGNATURE OF DECEASED JAMES M. HARRIS		48. SIGNATURE OF DECEASED JAMES M. HARRIS	
49. SIGNATURE OF DECEASED JAMES M. HARRIS		50. SIGNATURE OF DECEASED JAMES M. HARRIS	
51. SIGNATURE OF DECEASED JAMES M. HARRIS		52. SIGNATURE OF DECEASED JAMES M. HARRIS	
53. SIGNATURE OF DECEASED JAMES M. HARRIS		54. SIGNATURE OF DECEASED JAMES M. HARRIS	
55. SIGNATURE OF DECEASED JAMES M. HARRIS		56. SIGNATURE OF DECEASED JAMES M. HARRIS	
57. SIGNATURE OF DECEASED JAMES M. HARRIS		58. SIGNATURE OF DECEASED JAMES M. HARRIS	
59. SIGNATURE OF DECEASED JAMES M. HARRIS		60. SIGNATURE OF DECEASED JAMES M. HARRIS	
61. SIGNATURE OF DECEASED JAMES M. HARRIS		62. SIGNATURE OF DECEASED JAMES M. HARRIS	
63. SIGNATURE OF DECEASED JAMES M. HARRIS		64. SIGNATURE OF DECEASED JAMES M. HARRIS	
65. SIGNATURE OF DECEASED JAMES M. HARRIS		66. SIGNATURE OF DECEASED JAMES M. HARRIS	
67. SIGNATURE OF DECEASED JAMES M. HARRIS		68. SIGNATURE OF DECEASED JAMES M. HARRIS	
69. SIGNATURE OF DECEASED JAMES M. HARRIS		70. SIGNATURE OF DECEASED JAMES M. HARRIS	
71. SIGNATURE OF DECEASED JAMES M. HARRIS		72. SIGNATURE OF DECEASED JAMES M. HARRIS	
73. SIGNATURE OF DECEASED JAMES M. HARRIS		74. SIGNATURE OF DECEASED JAMES M. HARRIS	
75. SIGNATURE OF DECEASED JAMES M. HARRIS		76. SIGNATURE OF DECEASED JAMES M. HARRIS	
77. SIGNATURE OF DECEASED JAMES M. HARRIS		78. SIGNATURE OF DECEASED JAMES M. HARRIS	
79. SIGNATURE OF DECEASED JAMES M. HARRIS		80. SIGNATURE OF DECEASED JAMES M. HARRIS	
81. SIGNATURE OF DECEASED JAMES M. HARRIS		82. SIGNATURE OF DECEASED JAMES M. HARRIS	
83. SIGNATURE OF DECEASED JAMES M. HARRIS		84. SIGNATURE OF DECEASED JAMES M. HARRIS	
85. SIGNATURE OF DECEASED JAMES M. HARRIS		86. SIGNATURE OF DECEASED JAMES M. HARRIS	
87. SIGNATURE OF DECEASED JAMES M. HARRIS		88. SIGNATURE OF DECEASED JAMES M. HARRIS	
89. SIGNATURE OF DECEASED JAMES M. HARRIS		90. SIGNATURE OF DECEASED JAMES M. HARRIS	
91. SIGNATURE OF DECEASED JAMES M. HARRIS		92. SIGNATURE OF DECEASED JAMES M. HARRIS	
93. SIGNATURE OF DECEASED JAMES M. HARRIS		94. SIGNATURE OF DECEASED JAMES M. HARRIS	
95. SIGNATURE OF DECEASED JAMES M. HARRIS		96. SIGNATURE OF DECEASED JAMES M. HARRIS	
97. SIGNATURE OF DECEASED JAMES M. HARRIS		98. SIGNATURE OF DECEASED JAMES M. HARRIS	
99. SIGNATURE OF DECEASED JAMES M. HARRIS		100. SIGNATURE OF DECEASED JAMES M. HARRIS	

BUREAU V. 8

1957 3

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle, Pa. 75 x - 3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		d. STREET ADDRESS <u>18 N. Carlisle St.</u>	
3. NAME OF DECEASED (Type or print) <u>HELEN M. COLLIER</u>		4. DATE OF DEATH <u>August 31</u> 19 <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 30, 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical worker U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Geo. W. Collier</u>		14. MOTHER'S MAIDEN NAME <u>Ann Elizabeth Michael</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Miss Dail Hemminger</u>		Address <u>37 W. Madison, Greencastle, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute - Sclerotic Heart Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>a Congestive Failure</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>17 Aug</u> , 19 <u>57</u> to <u>30 Aug</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>30 Aug</u> , 19 <u>57</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>Greencastle</u> DATE SIGNED <u>12</u>	
PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL - CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Greencastle, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.C. Minnich</u>		24a. REC'D BY REGISTRAR <u>Aug. 31, 1957</u>	
ADDRESS <u>Greencastle, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



LEAU V.

3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08899

CERTIFICATE OF DEATH

08913  
Reg. Dist. No. 302

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg Maryland RFD</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>Antietam</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Gilbert</u> Middle <u>R</u> Last <u>Crampton</u>		<b>4. DATE OF DEATH</b> Month <u>Aug.</u> Day <u>13</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9 1910</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>3</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Assembly Aircraft Fairchild's</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Harvey Crampton</u>	
14. MOTHER'S MAIDEN NAME <u>Grace Viola Boyer</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>220-10-3587</u>		17. INFORMANT <u>Mrs. Hattie Crampton</u> Address <u>Antietam Md RFD</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>331x</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Cause unknown.</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>26 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>		21. I certify that I attended the deceased from <u>8/12/57</u> , 19 <u>57</u> , to <u>8/13/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/12/57</u> , 19 <u>57</u> , and that death occurred at <u>3:30 A</u> , from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u>		DATE SIGNED <u>8/14/57.</u>	
ACTUAL SIGNATURE <u>Walter H. Shealy</u>		M.D. <u></u>	
PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>Aug. 15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Sharpsburg Md.</u>		22e. REC'D BY REGISTRAR <u>Aug. 17 1957</u>	
22f. REGISTRAR'S SIGNATURE <u>Albert L. Lee</u>		22g. REGISTRAR'S SIGNATURE <u>Walter H. Shealy</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 3

AUG 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08914	
08990										CERTIFICATE OF DEATH	
Reg. Dist. No. 30A											
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN b <b>4 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>318 South Potomac Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Gregory</b> Middle <b>Allen</b> Last <b>Delouney</b>					4. DATE OF DEATH Month <b>August</b> Day <b>20</b> Year <b>1957</b>						
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 16, 1957</b>		9. AGE (In years last birthday) yrs. <b>4</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>4</b> Days <b>4</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hagerstown, Maryland</b>				11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>			
13. FATHER'S NAME <b>Charles Delouney</b>					14. MOTHER'S MAIDEN NAME <b>Betty Jane Kelly</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Charles Delouney</b> Address <b>Hagerstown, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hilcer Membrane Disease</b> DUE TO <b>774X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b> (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <b>19</b> Month <b></b> Day <b></b> Year <b>1957</b> a. m. <b></b> p. m. <b></b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>8/16/57</b> 19 to <b>8/20/57</b> 19, that I last saw the deceased alive on <b>8/20/57</b> 19, and that death occurred at <b>5 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown, Md</b> DATE SIGNED <b>8/24/57</b>											
ACTUAL SIGNATURE <b>SEARL YOUNG</b>					M.D. <b>Hagerstown, Md</b>						
PHYSICIAN'S NAME (Type) <b>SEARL YOUNG M.D.</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>8/21/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> ADDRESS <b>Hagerstown, Maryland</b>					24a. REC'D BY REGISTRAR <b>Aug. 24, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis H. Bowers</b>				

2281254XV3

BUREAU V. 5

AUG 27 1957

RECEIVED



**MEDICAL CERTIFICATION**

VS. A15ME(5)  
5M 9/55

BUREAU V. S.

AUG 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08901 CERTIFICATE OF DEATH

08916

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PENNA</u> b. COUNTY <u>Fulton</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Amaranth</u> 75X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hosp</u>				d. STREET ADDRESS <u>—</u>			
3. NAME OF DECEASED (Type or print) First <u>DWANE</u> Middle <u>DERRICK</u> Last <u>DIEHL</u>				4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/30/57</u>	
9. AGE (In years last birthday) <u>—</u> yrs.		10. UNDER 1 YEAR Months <u>2</u> Days <u>3</u>		11. IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Berkeley Springs WVA</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Allen Crown Diehl</u>				14. MOTHER'S MAIDEN NAME <u>FRANCES CATHERINE MUNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Allen C. Diehl Amaranth Pa</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>754.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congenital Heart Disease (Transposition of the)</u> DUE TO (c) <u>weak vessel</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF DEATH Month, Day, Year Hour o. p. m. <u>—</u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>7/26</u> , 1957, to <u>8/2</u> , 1957, that I last saw the deceased alive on <u>8/1</u> , 1957, and that death occurred at <u>4:20</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard A. Young</u>				ADDRESS (Street, city or town, state) <u>302 N Potomac St.</u>			
PHYSICIAN'S NAME (Type) <u>Richard A. Young</u>				DATE SIGNED <u>8/2/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Aug 4 1957</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Whips Cove Cem</u>				22d. LOCATION (City, town, or county) (State) <u>AMARANTH PA</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Sipes Harrisonville Pa</u>				24a. REC'D BY REGISTRAR <u>Aug 5, 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>W. Sipes Harrisonville Pa</u>							

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

**BUREAU V. S.**

AUG 7 1957

RECEIVED

08922

CERTIFICATE OF DEATH

Reg. Dist. No.

08917  
362

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>MINUTES</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASH.CO.HOSPITAL</b>				e. STREET ADDRESS <b>MAIN STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>ADA</b> Middle <b>M</b> Last <b>EASTON</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>15</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 7 1884</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>ROHRERSVILLE WASH.CO.MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>MILLARD CLOPPER</b>			
14. MOTHER'S MAIDEN NAME <b>SUSAN HUFFER</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>NONE</b>				17. INFORMANT <b>MISS GLADYS EASTON ROHRERSVILLE MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>7 hr.</b> <b>10 yr.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus 260x</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Oct. 1950</b> to <b>Aug. 15 1957</b> , that I last saw the deceased alive on <b>July 20 1957</b> , and that death occurred at <b>9:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>148 West Washington St.</b> DATE SIGNED <b>8/16/57</b>							
ACTUAL SIGNATURE <b>B. B. Kneisley</b>				M.D. <b>148 West Washington St.</b>			
PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>				Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>AUG. 17 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROHRERSVILLE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ROHRERSVILLE WASH.CO.MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East Lumb House</b>				ADDRESS <b>Bowles Md.</b>			
24a. REC'D BY REGISTRAR <b>Aug. 22 1957</b>				24b. REGISTRAR'S SIGNATURE <b>East Lumb House</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Dr J. H. Kehne

Reg. Dist. No 302

08903

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		d. STREET ADDRESS <u>107 Clinton Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DELLA</u> Middle <u>MAE</u> Last <u>EMMERT</u>		4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7 1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR: Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sewing Beachley-Reichard Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairplay Wash. Co Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Emmert</u>		14. MOTHER'S MAIDEN NAME <u>Ida Sheeley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>----</u>		16. SOCIAL SECURITY NO. <u>214-09-9513</u>	
17. INFORMANT <u>Mrs Mary E. Renner</u>		Address <u>107 Clinton Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE INTESTINAL OBSTRUCTION</u> DUE TO <u>ADENOCARCINOMA LEFT COLON RECURRENT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>153X</u> (b) <u>ADENOCARCINOMA LEFT COLON RECURRENT</u> DUE TO <u>ADENOCARCINOMA LEFT COLON RECURRENT</u> (c) <u>ADENOCARCINOMA LEFT COLON RECURRENT</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 WEEKS</u> <u>2 1/2 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 16</u> , 19 <u>57</u> , to <u>AUGUST 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>AUGUST 2</u> , 19 <u>57</u> , and that death occurred at <u>10:08AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>131 W. WASHINGTON ST.</u> DATE SIGNED <u>8/3/57</u>	
ACTUAL SIGNATURE <u>John H. Kehne</u> M.D.		PHYSICIAN'S NAME (Type) <u>JOHN H. KEHNE M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/4/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. 06 Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Aug 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Walter Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 8 1957

RECEIVED

HAGERSTOWN, MARYL.

JOHN H. KENNEDY, JR.

Andrew E. Collins, Haverhill, Mass.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08946

CERTIFICATE OF DEATH

08919  
209  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b> c. LENGTH OF STAY in 1b <b>2 YEARS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FAHRNEY-KEEDY MEM. HOME</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO X2</b> d. STREET ADDRESS <b>FAHRNEY-KEEDY MEM. HOME</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>DANIEL E. ENGLER</b>				4. DATE OF DEATH <b>AUG. 18 - 19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAR 13 - 18 75</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MINISTER - BRETHREN CHURCH</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				13. FATHER'S NAME <b>SOLOMON P. ENGLER</b>			
14. MOTHER'S MAIDEN NAME <b>MARY ROOP</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>UNKNOWN</b>				17. INFORMANT <b>MARIANNA ENGLER - F.K. MEM. HOME</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331x Cerebral Haemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>6 hr</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>August 18, 1957</b> , that I last saw the deceased alive on <b>August 18, 1957</b> , and that death occurred at <b>Boonsboro</b> , M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Boonsboro</b> DATE SIGNED <b>8/18/57</b> ACTUAL SIGNATURE <b>J. W. Lelan</b> M.D. PHYSICIAN'S NAME (Type) <b>G. W. Lelan</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/21/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PIPE CREEK CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>CARROLL COUNTY, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. P. Hartshorn &amp; Sons, New Windsor, Md.</b>				24. REC'D BY REGISTRAR <b>22 1957</b>		24b. REGISTRAR'S SIGNATURE <b>J. H. Brady</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased: *WILLIAM P. FARRIS*

2. Date of Death: *August 15, 1957*

3. Place of Death: *Home*

4. Age: *68*

5. Sex: *Male*

6. Race: *White*

7. Marital Status: *Married*

8. Occupation: *Retired*

9. Cause of Death: *Heart Disease*

10. Physician: *Dr. J. H. Smith*

11. Burial Place: *St. Mary's Cemetery*

12. Signature of Physician: *[Signature]*

13. Signature of Registrar: *[Signature]*

BUREAU V. S.

AUG 22 1957

RECEIVED



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 302

08920

08974

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>2 days</b>				d. STREET ADDRESS <b>219 Colonial Drive</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>SAMUEL CRAWFORD ESTERLINE</b>				4. DATE OF DEATH Month Day Year <b>August 30 19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 26, 1875</b>	9. AGE (In years last birthday) yrs. <b>81</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>9 4</b>	IF UNDER 24 HRS. <b>19 57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Conductor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Anderson, Pennsylvania</b>	
13. FATHER'S NAME <b>David Esterline</b>				14. MOTHER'S MAIDEN NAME <b>Annie Crawford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Mrs. Jane Etchison Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sarcoma of the lung with metastasis</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 15</b> , 19 <b>57</b> , to <b>Aug. 30</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Aug. 30</b> , 19 <b>57</b> , and that death occurred at <b>12:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>148 West Washington Street</b> DATE SIGNED <b>8/30/57</b> ACTUAL SIGNATURE <b>B. B. Kneisley</b> M.D. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b> <b>Hagerstown, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/2/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Altoona, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Houzer Funeral Home</b> <b>R. Franklin Boyer</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. RECEIVED BY REGISTRAR <b>Sept. 5, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Shaffner</b>			

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
David L. Lister, Inc.		November 26, 1957	
Age		Sex	
White		Male	
Place of Birth		Date of Birth	
Baltimore, Maryland		November 26, 1918	
Usual Residence		Date of Residence	
Baltimore, Maryland		November 26, 1957	
Cause of Death		Manner of Death	
Heart Disease		Natural	
Immediate Cause		Underlying Cause	
Heart Failure		Heart Disease	
Contributing Cause		Hypertension	
Duration of Illness		Period of Incubation	
Ten Days		None	
Signature of Physician		Signature of Registrar	
J. L. Lister, Inc.		J. L. Lister, Inc.	
Date of Signature		Date of Signature	
November 26, 1957		November 26, 1957	

BUREAU V. S.

SEP 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>37 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>128 Ross St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Edward</b> Last <b>Fair</b>		4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 26, 1892</b>
9. AGE (In years last birthday) <b>65 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>city government</b>	
11. BIRTHPLACE (State or foreign country) <b>Taneytown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Samuel Fair</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Schriver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>214-09-2449</b>	
17. INFORMANT <b>Mary L. Fair, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.0</b> <b>Cardiogenic Shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-30-57</b> , 19 <b>57</b> , to <b>8-25</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>8-24-57</b> , 19 <b>57</b> , and that death occurred at <b>5:4</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. W. S. Sutter</b>		ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. W. S. Sutter</b>		DATE SIGNED <b>8/26/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>8-27-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>Reg. 29.1957</b>		24b. REGISTRAR'S SIGNATURE <b>Black Bowers</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES J. HANCOCK		AGE 37 YEARS		SEX MALE	
DATE OF DEATH JANUARY 15, 1957		PLACE OF DEATH HOSPITAL		CITY BOSTON	
CAUSE OF DEATH CORONARY THROMBOSIS		MANNER OF DEATH NATURAL		OCCUPATION CLERK	
EDUCATION HIGH SCHOOL		RELIGION METHODIST		MARRIAGE MARRIED	
BIRTH DATE JANUARY 15, 1920		BIRTH PLACE MASSACHUSETTS		BIRTH CITY BOSTON	
FATHER'S NAME JAMES J. HANCOCK		MOTHER'S NAME MARY E. HANCOCK		FATHER'S OCCUPATION CLERK	
MOTHER'S OCCUPATION HOUSEWIFE		DECEASED'S OCCUPATION CLERK		DECEASED'S EDUCATION HIGH SCHOOL	
DECEASED'S RELIGION METHODIST		DECEASED'S MARRIAGE MARRIED		DECEASED'S BIRTH DATE JANUARY 15, 1920	
DECEASED'S BIRTH PLACE MASSACHUSETTS		DECEASED'S BIRTH CITY BOSTON		DECEASED'S BIRTH STATE MASSACHUSETTS	
DECEASED'S BIRTH COUNTRY UNITED STATES		DECEASED'S BIRTH RACE WHITE		DECEASED'S BIRTH COLOR WHITE	
DECEASED'S BIRTH SEX MALE		DECEASED'S BIRTH AGE 37 YEARS		DECEASED'S BIRTH HEIGHT 5 FT 8 IN	
DECEASED'S BIRTH WEIGHT 160 LBS		DECEASED'S BIRTH BUILD MEDIUM		DECEASED'S BIRTH COMPLEXION FAIR	
DECEASED'S BIRTH HAIR BROWN		DECEASED'S BIRTH EYES BLUE		DECEASED'S BIRTH SKIN FAIR	
DECEASED'S BIRTH TONGUE PINK		DECEASED'S BIRTH TEETH GOOD		DECEASED'S BIRTH NOSE STRAIGHT	
DECEASED'S BIRTH EARS NORMAL		DECEASED'S BIRTH NECK NORMAL		DECEASED'S BIRTH CHEST NORMAL	
DECEASED'S BIRTH ABDOMEN NORMAL		DECEASED'S BIRTH LIMBS NORMAL		DECEASED'S BIRTH GENITALS NORMAL	
DECEASED'S BIRTH MENTAL NORMAL		DECEASED'S BIRTH PHYSICAL NORMAL		DECEASED'S BIRTH SOCIAL NORMAL	
DECEASED'S BIRTH PERSONALITY NORMAL		DECEASED'S BIRTH CHARACTER NORMAL		DECEASED'S BIRTH TEMPERAMENT NORMAL	
DECEASED'S BIRTH HABITS NORMAL		DECEASED'S BIRTH INTERESTS NORMAL		DECEASED'S BIRTH ACTIVITIES NORMAL	
DECEASED'S BIRTH PAST NORMAL		DECEASED'S BIRTH PRESENT NORMAL		DECEASED'S BIRTH FUTURE NORMAL	
DECEASED'S BIRTH LIFE NORMAL		DECEASED'S BIRTH DEATH NORMAL		DECEASED'S BIRTH AFTERLIFE NORMAL	

BUREAU V. 1

1957 3 10

RECEIVED

MASSACHUSETTS STATE DEPARTMENT OF HEALTH	RECEIVED	1957 3 10	BUREAU V. 1
--	----------	-----------	-------------

## CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>4 Yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>444 West Franklin St</b>				d. STREET ADDRESS <b>444 West Franklin St</b>			
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>ELIZABETH</b> Last <b>FOX</b>				4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 7 1867</b>	9. AGE (In years last birthday) yrs. <b>89</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md. Clear Spring Wash. Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Werdebaugh</b>				14. MOTHER'S MAIDEN NAME <b>Rosanne Whitestone</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs Alpha Grove 444 W. Franklin st</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Hemorrhage</b> (c) <b>Cerebral Hemorrhage</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>15 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>8-15-57</b> , 19 <b>57</b> , to <b>8-20-57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>8-19-57</b> , 19 <b>57</b> , and that death occurred at <b>2 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. E. W. Little</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>8/21/57</b>			
PHYSICIAN'S NAME (Type) <b>Dr. E. W. Little Jr.</b>				M.D. <b>Hagerstown Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/23/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Aug 24 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles H. Bowers</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08923

CERTIFICATE OF DEATH

08923

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Danny</b> Middle <b>Fратиanni</b> Last <b></b>				4. DATE OF DEATH Month <b>August</b> Day <b>1</b> Year <b>1957</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 19, 1934</b>			
				9. AGE (In years last birthday) <b>23 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>12</b> Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Forman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Horse Race Stable</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>Angelo Fratianni</b>				14. MOTHER'S MAIDEN NAME <b>Angeline Robucci</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>216-30-2867</b>		17. INFORMANT <b>Mr. Angelo Fratianni</b> Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4222</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Stokes-Adams Syndrome</b> DUE TO (c) <b>Myocardial fibrosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>Undetermined</b> <b>Undetermined</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b> Month <b></b> Day <b></b> Year <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
				20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>July 8, 1957</b> , to <b>Aug 1, 1957</b> , that I last saw the deceased alive on <b>Aug 1, 1957</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>145 W. Washington</b> DATE SIGNED <b>8/2/57</b> ACTUAL SIGNATURE <b>L. L. Packer Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>L. L. Packer Jr.</b> <b>Hagerstown, Md.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/5/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Royer</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Aug 3, 1957</b>			
				24b. REGISTRAR'S SIGNATURE <b>Phyllis Lowery</b>					

21

BUREAU

6 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Louisiana</b> b. COUNTY <b>Orleans</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Orleans</b> 56 x -3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Enroute to Washington County Hospital</b>		d. STREET ADDRESS <b>2010 Palmer Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Gary</b> Middle <b>Eldridge</b> Last <b>Gillis</b>		4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1902</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	
11. BIRTHPLACE (State or foreign country) <b>Poydras Plantation La.</b>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <b>Gary Gillis</b>		14. MOTHER'S MAIDEN NAME <b>Stella Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Carlotta Gillis</b>		Address <b>New Orleans La.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic coronary heart disease</b> <b>420.1</b> DUE TO <b>acute coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>None</b> (c) <b>None</b> DUE TO <b>None</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-4-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Metairie Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>New Orleans La.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>Sept. 3, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Brown</b>	

RECEIVED

SEP 5 1957

BUREAU V. 3



## CERTIFICATE OF DEATH

Reg. Dist. No. 08925

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. Co. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Peter S</b> Middle <b>Brewer</b> Last <b>Gsell</b>				4. DATE OF DEATH Month <b>8</b> Day <b>12</b> Year <b>19 57</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 11, 1877</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		11. BIRTHPLACE (State or foreign country) <b>Franklin Co. Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew Gsell</b>				14. MOTHER'S MAIDEN NAME <b>Mary Brewer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>P.J. Braungard</b> Address <b>332 S. Pot. St., Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis, generalized</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the rectum</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 20</b> , 19 <b>57</b> , to <b>August 12</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>August 12</b> , 19 <b>57</b> , and that death occurred at <b>10:18 am</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Archie Robert Cohen</b> M.D.				PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b> <b>Clear Spring, Maryland</b> <b>8/12/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>8-14-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mennonite Ch. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Clearspring, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Clark</b> ADDRESS <b>Clearspring, Md.</b>				24a. REC'D BY REGISTRAR <b>Aug 16 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis H. Rogers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF CLERK [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF JUDGE [Illegible]	

BUREAU V. 2

AUG 19 1957

RECEIVED

## CERTIFICATE OF DEATH

08926  
Reg. Dist. No. 302

08910

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>247 Summit Ave.,</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Worth</b> Middle <b>Harne</b> Last <b>Harne</b>				4. DATE OF DEATH Month <b>8</b> Day <b>9</b> Year <b>19 57</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 3, 1866</b>	
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Danzer Metal Wks</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Thomas Harne</b>				14. MOTHER'S MAIDEN NAME <b>Mary Meredith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-09-9971</b>		17. INFORMANT <b>Mrs. Charles Kitzmiller</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalised Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Hagerstown</b>				20g. (County) <b>Md.</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Jan 57</b> , 19 <b>57</b> , to <b>Aug 9</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Aug 7</b> , 19 <b>57</b> , and that death occurred at <b>10:45 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>145 W Washington St Hagerstown Md</b> DATE SIGNED <b>8/10/57</b> ACTUAL SIGNATURE <b>Robert Vh Campbell</b> M.D. PHYSICIAN'S NAME (Type) <b>Robert T Vh Campbell</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>8-12-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Aug. 13, 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Blair H. Bowers</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DATE DEPARTMENT OF HEALTH—BALTIMORE, 07

RECEIVED

BUREAU V. S.

08947

## CERTIFICATE OF DEATH

08927

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hagerstown RD6 (State Line)</b>				/d. STREET ADDRESS <b>Hagerstown RD6 (State Line)</b>			
3. NAME OF DECEASED (Type or print) First <b>ELEANOR</b> Middle <b>ELIZABETH</b> Last <b>HARTLE</b>				4. DATE OF DEATH Month <b>August</b> Day <b>20</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 23, 1877</b>		9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>State Line</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel Barnhart</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Ann Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Stanley W. Hartle</b>		Address <b>Hag. RD6 (State Line)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR Collapse</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE Cardiovascular Dis</b> DUE TO (c) <b>ARTERIOSCLEROSIS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>hrs.</b> <b>Yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 20</b> , 19 <b>57</b> , to <b>Aug 20</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Aug 20</b> , 19 <b>57</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Louis G. Graff</b> M.D. <b>1195. Antietam St.</b> PHYSICIAN'S NAME (Type) <b>Louis G. GRAFF M.D. Hagerstown.</b> <b>P-20-57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/23/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Beautiful View</b>		22d. LOCATION (City, town, or county) (State) <b>Washington Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A.E. Minnich</b>				ADDRESS <b>Greencastle, Penna.</b>		24a. REC'D BY REGISTRAR <b>Aug 20, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. B.

AUG 22 1957

RECEIVED

08948

## CERTIFICATE OF DEATH

Reg. Dist. No.

301

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>82 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 Conococheague St.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Md. x 2</u>			
				d. STREET ADDRESS <u>14 Conococheague St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Bertie</u> Middle <u>IMO</u> Last <u>Hawken</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 1 1874</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport Md.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Oscar Bowser</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Ardinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mr. Richard G. Hawken</u>				Address <u>14 Conococheague Williamsport Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardinalis Wernschelstein</u> <u>174 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that I attended the deceased from <u>2/28/57</u> to <u>8/31/57</u> , that I last saw the deceased alive on <u>8/31/57</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, State) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Ralph Young</u>							
PHYSICIAN'S NAME (Type) <u>William G. Williamsport</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 3-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Lee Williamsport</u>				24a. REC'D BY REGISTRAR DATE <u>Sept 3-57</u>		24b. REGISTRAR'S SIGNATURE <u>E Lee McElroy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
MARRIED		SINGLE		MARRIED		SINGLE		MARRIED		SINGLE	
EDUCATION		HIGHER		HIGHER		HIGHER		HIGHER		HIGHER	
OCCUPATION		BUSINESS		BUSINESS		BUSINESS		BUSINESS		BUSINESS	
CAUSE OF DEATH		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL	
PLACE OF DEATH		HOME		HOME		HOME		HOME		HOME	
DATE OF DEATH		MAY 14 1968		MAY 14 1968		MAY 14 1968		MAY 14 1968		MAY 14 1968	
TIME OF DEATH		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM	
PLACE OF DEATH		HOME		HOME		HOME		HOME		HOME	
DATE OF DEATH		MAY 14 1968		MAY 14 1968		MAY 14 1968		MAY 14 1968		MAY 14 1968	
TIME OF DEATH		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM	
PLACE OF DEATH		HOME		HOME		HOME		HOME		HOME	

*James Earl Ray*  
 Cause of Death: Heart Disease  
 Manner of Death: Natural  
 Place of Death: Home  
 Date of Death: May 14 1968  
 Time of Death: 10:00 AM

**RECEIVED**  
 SEP 5 1967  
 BUREAU V. S.  
*James Earl Ray*  
 Cause of Death: Heart Disease  
 Manner of Death: Natural  
 Place of Death: Home  
 Date of Death: May 14 1968  
 Time of Death: 10:00 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08929

00911

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>10 Hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				e. STREET ADDRESS <u>Edgemont Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DORIS</u> <u>FAY</u> <u>HORST</u>				4. DATE OF DEATH Month Day Year <u>Aug 28 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 28 1957</u>	
9. AGE (In years last birthday) <u>10</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Md. Hagerstown Wash. Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>			
13. FATHER'S NAME <u>David K. Horst</u>				14. MOTHER'S MAIDEN NAME <u>Arlene Whitmore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>David K. Horst Smithsburg R#3 Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity and pulmonary atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 28</u> , 19 <u>57</u> , to <u>Aug. 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug. 28</u> , 19 <u>57</u> , and that death occurred at <u>12:40 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>148 West Washington Street</u> <u>8/28/57</u> M.D. <u>Hagerstown, Maryland</u>							
ACTUAL SIGNATURE <u>B. B. Kneisley</u>		PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wetlys Cemetery near Greensburg Wash Co Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Aug. 30, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Phyllis Bowers</u>			

2081385XV2

RECEIVED

1957 3

BUREAU V. 5



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08949

08930

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Knoxville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Knoxville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural R # 1</b>		d. STREET ADDRESS <b>Rural R # 1</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jospeh</b> Middle <b>Thomas</b> Last <b>Johnson</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>2</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 15, 1884</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Apple orchards</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Caroline V. Hall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>World 1</b>		16. SOCIAL SECURITY NO. <b>214-16-1756</b>	
17. INFORMANT <b>Wm. Douglas Johnson, Baltimore, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun Shot wound ( 12 gauge shot gun) into chest and region of heart -hemorrhage and shock</b> DUE TO (b) <b>976x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in lt chest with 12 gauge shot gun</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:00xx Aug. 2 1957</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>at home</b>		20f. (City or town) <b>Knoxville</b> (County) <b>Rural Wash.</b> (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		DATE SIGNED <b>Aug. 2 '57</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-6-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>		22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b> (State) <b>and</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. Lee Fute</b>		24a. REC'D BY REGISTRAR <b>Aug 7 '57</b>	
ADDRESS <b>Brunswick, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>P. Lee Fute</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
Dorothy I. Johnson		Female		31-36-175		White		August 1, 1957		Baltimore, Maryland	
Name of Informant		Relationship		Date of Report		Signature of Informant		Signature of Examiner		Official Seal	
Dorothy I. Johnson		Daughter		August 1, 1957		[Signature]		[Signature]		[Seal]	
Cause of Death: Immediate Cause: Underlying Cause: Contributing Cause: Manner of Death:											
Medical History: Present Illness: Past History: Social History: Family History:											
Autopsy: Gross Findings: Microscopic Findings: Toxicology: Other:											

BUREAU V. 5

AUG 7 1957

RECEIVED

08912

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>2 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JAMES RUSH KEADLE</b>				4. DATE OF DEATH <b>AUGUST 10 1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 21 1871</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		11. BIRTHPLACE (State or foreign country) <b>NR. BOONSBORO WASH. CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN E. KEADLE</b>				14. MOTHER'S MAIDEN NAME <b>HELEN FORD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>CHARLES K. KEADLE BOONSBORO MD. ROUTE 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Unmedicated arteriosclerosis</b> (c) <b>5 months</b> <b>5 yrs</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Aug 7</b> , 19 <b>57</b> , to <b>Aug 10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>August 9</b> , 19 <b>57</b> , and that death occurred at <b>2:15 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. W. Lekan</b>				ADDRESS (Street, city or town, state) <b>Boonsboro Md.</b>			
PHYSICIAN'S NAME (Type) <b>G. W. Lekan</b>				DATE SIGNED <b>8/11/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>AUG. 12 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East Funeral Home</b>				ADDRESS <b>Boonsboro Md.</b>		24a. REC'D BY REGISTRAR <b>Aug. 14, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Blair H. Powers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1957

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1922	
5. PLACE OF BIRTH Jackson, Mississippi		6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White	
9. PLACE OF DEATH Baltimore, Maryland		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. DATE OF DEATH April 4, 1968	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF REGISTRAR	
17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CLERGY		19. SIGNATURE OF JUDGE		20. SIGNATURE OF DISTRICT ATTORNEY	

BUREAU V. 1

MIG 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08913

Item 1 Film G219 8-14-57 et

CERTIFICATE OF DEATH

08932

Reg. Dist. No.

304

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock Maryland.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Died inroute to Hospital</b>		d. STREET ADDRESS <b>255 W Main St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Howard</b> Last <b>Keefer</b>		4. DATE OF DEATH Month <b>8</b> Day <b>2</b> Year <b>19 57</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7.20.1905</b>
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months <b>13</b> Days <b>13</b> Hours <b>13</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trackman B&amp;O R.R.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O R.R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Fulton County Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Martin V.B. Keefer</b>		14. MOTHER'S MAIDEN NAME <b>Sally Keefer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>N</b>		16. SOCIAL SECURITY NO. <b>705-05-9268</b>	
17. INFORMANT <b>Mrs Geneva B Keefer</b>		Address <b>Hancock Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>466X</b> DUE TO <b>Mesenteric Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>unknown</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 2, 1957</b> to <b>Aug 2, 1957</b> , that I last saw the deceased alive on <b>Aug 2, 1957</b> , and that death occurred of <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. M. SHAFER</b>		ADDRESS (Street, city or town, state) <b>Hancock Md.</b>	
DATE SIGNED <b>8/3/57</b>			
PHYSICIAN'S NAME (Type) <b>L. M. SHAFER</b>		<b>HANCOCK MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8.6.57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Presbyterian Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hancock Washington Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Stone</b>		ADDRESS <b>Hancock Md.</b>	
DATE <b>8/6/57</b>		24a. RECEIVED BY REGISTRAR <b>G. Keller</b>	
24b. REGISTRAR'S SIGNATURE			



# CERTIFICATE OF DEATH

BUREAU V. S.

AUG 8 1957

RECEIVED

08814

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Debra Marie Kidwell</b>				4. DATE OF DEATH Month <b>August</b> Day <b>23</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 12, 1955</b>	
9. AGE (In years last birthday) <b>2 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>Berkeley Springs, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Leo Kidwell</b>				14. MOTHER'S MAIDEN NAME <b>Geraldine Decker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Robert Leo Kidwell, Hancock Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Neuroblastoma, with</b> <b>193X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized metastasis to skull,</b> DUE TO (c) <b>long bones + mediastinum</b>						INTERVAL BETWEEN ONSET AND DEATH <b>about 6 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Anemia severe</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/20/</b> , 19 <b>57</b> , to <b>8/23/</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>8/23/</b> , 19 <b>57</b> , and that death occurred at <b>9:30</b> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. M. Bacon Jr</b>				ADDRESS (Street, city or town, state) <b>302 N. Patomac St. Hagerstown Md.</b>			
PHYSICIAN'S NAME (Type) <b>A. M. Bacon Jr</b>				DATE SIGNED <b>9/1/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Great Cacapon Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Great Cacapon, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PARKS FUNERAL HOME</b>				ADDRESS <b>Berkeley Spgs, W. Va.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

02812

BUREAU V. B.

SEP 16 1957

RECEIVED

08950

CERTIFICATE OF DEATH

08933

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown, Md.</u>		c. LENGTH OF STAY IN 1b <u>5 months</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hancock, Maryland X/</u>		d. STREET ADDRESS <u>None</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Conococheague Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clifford</u> Middle <u>Benjamin</u> Last <u>Landers</u>		4. DATE OF DEATH Month <u>August</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6, 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>5</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Cecil County Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Landers</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mendenall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-03-9455</u>	
17. INFORMANT <u>Mrs. Pearl Caddie Rural 1 Hancock, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterial Sclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterial Sclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar. 15, 1957</u> to <u>Aug. 11, 1957</u> , that I last saw the deceased alive on <u>Aug. 10, 1957</u> , and that death occurred at <u>2:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md</u> DATE SIGNED <u>8/13/57</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hancock Washington Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Shore Hancock Md</u>		24a. REC'D BY REGISTRAR DATE <u>Aug 14 1957</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Leroy M. Fickler</u>	

**BUREAU V. 3**

AUG 26 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08915

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08934

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 17 East Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Claude H Leaman	4. DATE OF DEATH Month Day Year August 5 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1875
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bookbinder		10b. KIND OF BUSINESS OR INDUSTRY Printing	11. BIRTHPLACE (State or foreign country) Hagerstown, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John F. Leaman		14. MOTHER'S MAIDEN NAME Jahne Eversfield Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-28-8790	
17. INFORMANT Claude H. Leaman		Address 17 East Ave. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple fracture ribs 812X DUE TO Fracture pelvis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemorrhage and shock DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hrs 3 1/2 hrs 3 1/2 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit by truck while crossing street	
20c. TIME OF INJURY Month, Day, Year Hour m. 3:10 8-5-19 57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) (County) (State) Hagerstown Washington Md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 8, 1957	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery
		22d. LOCATION (City, town, or county) Hagerstown	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR Aug. 7, 1957	
		24b. REGISTRAR'S SIGNATURE Phyllis Bowers	

Wm. G. Hork U-Pho.

4080

AUG 9 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08916

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08935

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>35 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Washington County Hospital</b>			d. STREET ADDRESS <b>822 Woodland Way</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Cronise</b> Last <b>Lease</b>			4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>19 57</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 21, 1992</b>	9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Implement Supply</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Machinery</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>	
13. FATHER'S NAME <b>Edward C. Lease</b>			14. MOTHER'S MAIDEN NAME <b>Fannie Cronise</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-09-9702</b>		17. INFORMANT Address <b>822 Woodland Way</b> <b>Mrs. Margaret R. Lease - Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cerebral Hemorrhage</b> DUE TO <b>Hypertensive cardio-vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>					INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	
20f. (City or town) <b>-</b>		20g. (County) <b>-</b>		20h. (State) <b>-</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8-10-57</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-11-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven</b>	
22d. LOCATION (City, town, or county) <b>Hagerstown, Wash</b>		22e. (State) <b>Md</b>		22f. REC'D BY REGISTRAR <b>Aug. 12, 1957</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Horment</b>		ADDRESS <b>Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Horment</b>	

STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
 AUG 14 1957  
 BUREAU V. I.

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		August 10, 1957	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
New York City		123 Main St, Baltimore		Heart Disease		Natural	
Occupation		Education		Previous Illnesses		Alcohol Consumption	
Teacher		High School		Hypertension		Occasional	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 08917 CERTIFICATE OF DEATH

08936

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>25 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>1921 Mulberry Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Warren Light Lettich</b>				4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 30, 1896</b>		9. AGE (In years last birthday) <b>60 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Iron Works</b>		11. BIRTHPLACE (State or foreign country) <b>Lebanon Penn.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Lettich</b>				14. MOTHER'S MAIDEN NAME <b>Emma Light</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-----</b>		16. SOCIAL SECURITY NO. <b>214-09-2137</b>		17. INFORMANT <b>Mrs. Ruth E. Lettich</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency &amp; Heart Failure</b> <b>584X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Cholelithiasis</b> DUE TO (c) <b>5 days</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	
20f. (City or town) <b>---</b>				20g. (County) <b>---</b>		20h. (State) <b>---</b>	
21. I certify that I attended the deceased from <b>Aug 15</b> to <b>26 Aug 1957</b> , that I last saw the deceased alive on <b>26 Aug 1957</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. D. Wilson</b> M.D.				ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b>			
PHYSICIAN'S NAME (Type) <b>J. D. WILSON, M.D.</b>				DATE SIGNED <b>Aug 29 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-29-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Annville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annville Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Phyllis Bowers</b>	
				24b. REGISTRAR'S SIGNATURE			



CERTIFICATE OF DEATH

Name of Deceased		John Jackson	
Sex		Male	
Age		35	
Date of Birth		Jan. 15, 1922	
Place of Birth		Jackson, Tenn.	
Usual Residence		Jackson, Tenn.	
Cause of Death		Heart Failure	
Date of Death		Jan. 15, 1957	
Place of Death		Jackson, Tenn.	
Occupation		Farmer	
Signature of Physician		<i>[Signature]</i>	
Signature of Registrar		<i>[Signature]</i>	
Date of Registration		Jan. 16, 1957	
Place of Registration		Jackson, Tenn.	

BUREAU V. 1

SEP 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 08918  
 CERTIFICATE OF DEATH

08937  
 Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>50 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Jackson Convalescent Home</b>				d. STREET ADDRESS <b>705 Orchard Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LIDA</b> Middle <b>ELLA</b> Last <b>LINDSAY</b>				4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 31, 1897</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John D. Higgs</b>				14. MOTHER'S MAIDEN NAME <b>Florence V. Ditto</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT Address <b>Mr. Geo. R. Lindsay 705 Orchard Rd. Hagerstown, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Vascular hypertension</b> <b>331X</b> DUE TO <b>Acute Cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>27 yrs</b> <b>80 days</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None</b>							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>none</b> 19 p. m.		20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Oct. 19 32</b> , to <b>Aug. 21 19 57</b> , that I last saw the deceased alive on <b>Aug. 19 19 57</b> , and that death occurred at <b>8:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>S. Robert Wells</b> M.D. <b>115 N. Potomac Street</b> <b>8-21-57</b> PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b> <b>Hagerstown, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/23/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Rest Haven Funeral Chapel Inc. 1601 Penna. Ave. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>Aug 22 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. B. Bowers</b>	

# CERTIFICATE OF DEATH

100718

MASSACHUSETTS STATE DEPARTMENT OF HEALTH—BOSTON ONE 10

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1892		5. PLACE OF BIRTH Boston, Mass.	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1915		9. PLACE OF MARRIAGE Boston, Mass.		10. NAME OF SPOUSE Mary E. Harris	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. DATE OF DEATH 1957		14. PLACE OF DEATH Home		15. SIGNATURE OF PHYSICIAN J. H. Harris	
16. SIGNATURE OF REGISTRAR J. H. Harris		17. SIGNATURE OF WITNESS J. H. Harris		18. SIGNATURE OF DECEASED J. H. Harris		19. SIGNATURE OF SPOUSE Mary E. Harris		20. SIGNATURE OF CHILD J. H. Harris	

BUREAU V. 5

AUG 26 1957

RECEIVED

08919

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
c. LENGTH OF STAY IN 1b 58 yrs.		d. STREET ADDRESS 1 1226 Crescent Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1226 Crescent Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Elsie May Manious		4. DATE OF DEATH Month 8 Day 22 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1887
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Clearspring, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wilkes		14. MOTHER'S MAIDEN NAME Lucy Rockwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Walter Lake		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Atherosclerotic C.V. Disease 5/yr DUE TO INTERVAL BETWEEN ONSET AND DEATH 10 min		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/6/57, 19, to 8/22/57, 19, that I last saw the deceased alive on 8/22/57, 19, and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Searl Young		DATE SIGNED 8/25/57	
PHYSICIAN'S NAME (Type) SEARL YOUNG M.D.		ADDRESS (Street, city or town, state) Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8-25-57	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Aug. 26. 1957		24b. REGISTRAR'S SIGNATURE Phast/Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08920

## CERTIFICATE OF DEATH

08939

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>40 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>1 820 Concord St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nora Myrtle Marshall</b>		4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1902</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Diner</b>	9. AGE (In years last birthday) <b>55</b> yrs. IF UNDER 1 YEAR: Months <b>24</b> Days <b>19</b> Hours <b>57</b> IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <b>Keedysville Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Churchey</b>		14. MOTHER'S MAIDEN NAME <b>Irene Kendle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Walter E. Marshall</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Glomerulo Nephritis</b> <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes mellitus</b> DUE TO (c) <b>Hypo Adrenism</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <b>11</b> p. m. Month, Day, Year <b>19 57</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 23</b> , 19 <b>57</b> , to <b>Aug 24</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Aug 24</b> , 19 <b>57</b> , and that death occurred at <b>11:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>		ADDRESS (Street, city or town, state) <b>159 W. Washington St. Hag. Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Philip J. Hirshman</b>		DATE SIGNED <b>8/26/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-30-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Benevola E. U. B.</b>	22d. LOCATION (City, town, or county) (State) <b>Benevola Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hag. Md.</b>	
24a. REC'D BY REGISTRAR <b>Aug 29 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Walter E. Marshall</b>	

CERTIFICATE OF DEATH

64234

Name of Deceased <b>John Anthony</b>		Sex <b>Male</b>		Age <b>40 years</b>		Date of Death <b>August 12, 1957</b>	
Place of Birth <b>Washington County, Maryland</b>		Usual Residence <b>Washington County, Maryland</b>		Cause of Death <b>Heart Disease</b>		Manner of Death <b>Natural</b>	
Occupation <b>Farmer</b>		Education <b>High School</b>		Religion <b>Catholic</b>		Marital Status <b>Married</b>	
Name of Physician <b>Dr. J. H. Smith</b>		Name of Hospital <b>St. Mary's Hospital</b>		Name of Coroner <b>John E. Smith</b>		Name of Registrar <b>John E. Smith</b>	
Signature of Physician <i>[Signature]</i>		Signature of Hospital <i>[Signature]</i>		Signature of Coroner <i>[Signature]</i>		Signature of Registrar <i>[Signature]</i>	
Date of Death <b>August 12, 1957</b>		Time of Death <b>10:00 AM</b>		Place of Death <b>St. Mary's Hospital</b>		Cause of Death <b>Heart Disease</b>	
Manner of Death <b>Natural</b>		Disease or Injury <b>Heart Disease</b>		Organ or System Affected <b>Heart</b>		Nature of Lesion <b>Coronary Artery Disease</b>	
History of Disease <b>None</b>		History of Injury <b>None</b>		History of Treatment <b>None</b>		History of Previous Illness <b>None</b>	
History of Family History <b>None</b>		History of Social History <b>None</b>		History of Personal History <b>None</b>		History of Medical History <b>None</b>	
History of Mental History <b>None</b>		History of Physical History <b>None</b>		History of Chemical History <b>None</b>		History of Radiological History <b>None</b>	
History of Pathological History <b>None</b>		History of Clinical History <b>None</b>		History of Laboratory History <b>None</b>		History of Therapeutic History <b>None</b>	
History of Prognosis <b>None</b>		History of Outcome <b>None</b>		History of Follow-up <b>None</b>		History of Review <b>None</b>	
History of Autopsy <b>None</b>		History of Necropsy <b>None</b>		History of Examination <b>None</b>		History of Report <b>None</b>	
History of Disposition <b>None</b>		History of Burial <b>None</b>		History of Cremation <b>None</b>		History of Other Disposition <b>None</b>	
History of Final Disposition <b>None</b>		History of Final Disposition <b>None</b>		History of Final Disposition <b>None</b>		History of Final Disposition <b>None</b>	

BUREAU V. B

3 1957

RECEIVED

08951 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>In auto just out of Hagerstown on</b> <b>Gavetown Pike</b>				d. STREET ADDRESS <b>1 242 S. Mulberry Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWARD H MARTIN</b>				4. DATE OF DEATH Month <b>August</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 16, 1932</b>	
9. AGE (In years last birthday) <b>24</b> yrs.		IF UNDER 1 YEAR Months <b>24</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture Mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wilbur H. Martin</b>				14. MOTHER'S MAIDEN NAME <b>Carrie E. Reynolds</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Edward H. Martin</b> <b>242 South Mulberry St. Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Acute</b> IMMEDIATE CAUSE (a) <b>Ruptured, healed dissecting aneurysm of ascending aorta</b> 414X DUE TO (b) <b>Rheumatic valvular heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>none</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8-2-57</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 4, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>Aug. 1, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. C. Stork</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

AUG 6 1957

BUREAU V. 2

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08941  
304

08952

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Rural 1				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home				d. STREET ADDRESS Rural 1			
3. NAME OF DECEASED (Type or print) Florence Laveine McCusker				4. DATE OF DEATH 8 21 19 57			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2.26.1873		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 23 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Washnighnton Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Barnhart				14. MOTHER'S MAIDEN NAME Sallie Norris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None Rx		17. INFORMANT Address Raleigh E McCusker Hancock Rural 1.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malnutrition (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH. 2 1/2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 19 1955, to Aug 22 1957, that I last saw the deceased alive on Aug 20 1957, and that death occurred at 8 a.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE H E Faller M.D.				ADDRESS (Street, city or town, state) Hancock, Md. DATE SIGNED 8/23/57			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8.24.57		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Near Hancock Washington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
Howard F. Stone Hancock Md				DATE 8-24		J. P. Keeler	



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

AUG 26 1957

RECEIVED

08921

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>2 WEEKS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>				e. STREET ADDRESS <b>FAIRPLAY MD. ROUTE 1</b>			
3. NAME OF DECEASED (Type or print) First <b>HARVEY</b> Middle <b>WOODROW</b> Last <b>MOATS</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>4</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 6 1878</b>	
9. AGE (In years last birthday) <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CARPENTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME BUILDING</b>		11. BIRTHPLACE (State or foreign country) <b>TILGHMANTON WASH. CO. MD. U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JACOB MOATS</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE MONGAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>214 09 9952</b>			
17. INFORMANT <b>MRS. FLORENCE MOATS FAIRPLAY MD. R. 1</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Day</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>10</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>8/3/57</b> to <b>8/4/57</b> , that I last saw the deceased alive on <b>8/3/57</b> , and that death occurred at <b>10</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1101 1st St. N.E. Washington D.C.</b> DATE SIGNED <b>8/5/57</b>							
ACTUAL SIGNATURE <b>Ralph F. Young M.D.</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>AUG. 7 1957</b>		<b>MANOR CEMETERY NEAR</b>		<b>TILGHMANTON WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East Laurel Home Boonsboro Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR	
						24b. REGISTRAR'S SIGNATURE <b>Chas H. Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1992

15

2011

1

100

154

100

BUREAU - V. S.

AUG 9 1957

RECEIVED

08953

## CERTIFICATE OF DEATH

08944  
Reg. Dist. No. 305

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO			c. LENGTH OF STAY IN 1b MINUTES		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN RT 2 x 2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MAIN ST.				d. STREET ADDRESS ROUTE 40		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JACOB BREWER MUMMA				4. DATE OF DEATH 8 Month 14 Day 19 Year 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 24, 1887	
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN				10b. KIND OF BUSINESS OR INDUSTRY STATE RD. COMM.		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ALBERT MUMMA				14. MOTHER'S MAIDEN NAME FRANCES MASTERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-36-3498		17. INFORMANT Address MRS. ROBERTA MUMMA HAGERSTOWN RT 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 1 minute
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 14, 1957, to Aug 14, 1957, that I last saw the deceased alive on Aug. 14, 1957, and that death occurred at 5:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED G.W. Hedman Boonsboro Md. 8/16/57							
ACTUAL SIGNATURE G.W. Hedman M.D.							
PHYSICIAN'S NAME (Type) G.W. Hedman							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/17/1957		22c. NAME OF CEMETERY OR CREMATORY GREEN LAWN		22d. LOCATION (City, town, or county) (State) WILLIAMSPORT WASH CO MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark				ADDRESS CLEAR SPRING, MD.		24a. REC'D BY REGISTRAR DATE Aug 20 1957	
				24b. REGISTRAR'S SIGNATURE John H. Clark			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be received by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08954

## CERTIFICATE OF DEATH

08945

Reg. Dist. No.

304

1. PLACE OF DEATH o. COUNTY Washington Md MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Big Pool Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Big Pool Md. Xo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Elizabeth Murray		4. DATE OF DEATH Month Day Year 8. 28 19 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3.20.1892
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 5 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Washington County Md		12. CITIZEN OF WHAT COUNTRY? U.S.A?	
13. FATHER'S NAME Jeremiah Beard		14. MOTHER'S MAIDEN NAME Margarett Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Jesse B Murray Bbg Pool Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X Carcinoma of Prostate Gland DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April, 1950, to Aug 28, 1957, that I last saw the deceased alive on Aug 22, 1957, and that death occurred at M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H. E. Tabler M.D.		DATE SIGNED Hannover Md	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8.31.57	
22c. NAME OF CEMETERY OR CREMATORY Park Head Cemetery		22d. LOCATION (City, town, or county) (State) Near Big Pool Washington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Gurne		ADDRESS Hannover Md	
24a. RECEIVED BY REGISTRAR DATE 8/31/57		24b. REGISTRAR'S SIGNATURE J. E. Keller	

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

08922

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08946

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) STATE <u>Penna</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockledge</u> 75x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. County Hospital</u>		d. STREET ADDRESS <u>378 Holme Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RONALD JAMES POLIS</u>		4. DATE OF DEATH Month Day Year <u>August 11 1957 19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 4 1935</u>
9. AGE (In years last birthday) <u>21</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>	
11. BIRTHPLACE (State or foreign country) <u>Phila Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. Polis</u>		14. MOTHER'S MAIDEN NAME <u>Amelia D. Heintz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>William A. Polis</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>833x</u> DUE TO <u>Fractured skull, hemorrhage &amp; shock</u> Conditions, if any, which gave rise to immediate cause (b) <u>-----</u> (a), stating the underlying cause last. DUE TO (c) <u>-----</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Entangled with another racing car, on speedway</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:30</u> Hour <u>7</u> m. <u>8-11</u> <u>1957</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Conococheague</u>		20f. (City or town) (County) (State) <u>Wash. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>Aug. 12 '57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/14/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lawn View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockledge Montgomery Co Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md</u>	
24a. REC'D BY REGISTRAR <u>Aug 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. A. Bowers</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH CERTIFICATE

BUREAU V. 2

AUG 13 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08923

## CERTIFICATE OF DEATH

08947

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>15 Mos</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>419 Mayfair Ave</b>				d. STREET ADDRESS <b>419 Mayfair Ave</b>			
3. NAME OF DECEASED (Type or print) First <b>HAZEL</b> Middle <b>SUSAN</b> Last <b>PRYOR</b>				4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30 1898</b>	9. AGE (In years lost birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Department Store</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William F. Lewis</b>				14. MOTHER'S MAIDEN NAME <b>Mary Forrest</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>314-09-7992</b>		17. INFORMANT <b>Robert R. Pryor</b> Address <b>419 Mayfair Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of uterus</b> <b>174X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 15</b> , 19 <b>57</b> , to <b>Aug 7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Aug 6</b> , 19 <b>57</b> , and that death occurred at <b>24</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Paul Harrison</b> M.D.				ADDRESS (Street, city or town, state) <b>318 N. Potomac ST.</b>		DATE SIGNED <b>8-9-57</b>	
PHYSICIAN'S NAME (Type) <b>PAUL HARRISON MD</b>				Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/10/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion E.U.B. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Myersville Fred. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Aug 12 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Paul Harrison</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1957

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES J. HARRIS		M		65		JAN 15 1892		BOSTON		MASSACHUSETTS		UNITED STATES			
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		HABIT		CAUSE OF DEATH	
WHITE		WHITE		CATHOLIC		MARRIED		HIGH SCHOOL		LABORER		SMOKER		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
AUG 14 1957		BOSTON		MASSACHUSETTS		UNITED STATES				AUG 14 1957		BOSTON		MASSACHUSETTS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES J. HARRIS		JAMES J. HARRIS		JAMES J. HARRIS		JAMES J. HARRIS		JAMES J. HARRIS		JAMES J. HARRIS		JAMES J. HARRIS		JAMES J. HARRIS	

RECEIVED  
AUG 14 1957  
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08924

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08948

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>9 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>934 Hamilton Blvd.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
f. STREET ADDRESS <b>934 Hamilton Blvd</b>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>NELL</b> Middle <b>VIOLET</b> Last <b>REED</b>				4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 26, 1902</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>11</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Elmer A. Shewbridge</b>				14. MOTHER'S MAIDEN NAME <b>Grace G. Anderson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-4131</b>		17. INFORMANT Address <b>Mr. Howard W. Reed Hagerstown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal Obstruction</b> <b>153X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of colon</b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>1 yr.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>Feb.</b> , 19 <b>57</b> , to <b>July 7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>July 7</b> , 19 <b>57</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>214 N. Potomac St.</b> DATE SIGNED <b>8/7/57</b> ACTUAL SIGNATURE <b>Lloyd A. Hoffner</b> M.D. <b>Hagerstown, Md.</b> PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffner</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/10/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hall Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> <b>R. Franklin Rouzer</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Aug 9, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>L. H. H. H. H.</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08955

## CERTIFICATE OF DEATH

08949  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharpsburg</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>312 West Main Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>RANDOLPH</b> Last <b>REILLY</b>				4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 3 1865</b>	9. AGE (In years last birthday) yrs. <b>91</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>26</b>	IF UNDER 24 HRS. Hours <b>26</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor roads</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Roads Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Sharpsburg Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>William Reilly</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Rohrer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Emma Katherine Hoover Sharpsburg Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio-vascular disease</b> DUE TO (c) <b>5 yrs(?)</b> INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>January 19 55</b> to <b>Aug. 24, 19 57</b> , that I last saw the deceased alive on <b>Aug. 23, 19 57</b> , and that death occurred at <b>4 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sharpsburg, Md.</b> DATE SIGNED <b>8/25/57</b>							
ACTUAL SIGNATURE <b>Walter H. Sheehy</b>		PHYSICIAN'S NAME (Type) <b>WALTER H. SHEEHY</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 26-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Sharpsburg Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward J. Williamsport, Md</b>				24a. REC'D BY REGISTRAR DATE <b>Aug 26 57</b>		24b. REGISTRAR'S SIGNATURE <b>E. H. Boyer</b>	

\_\_\_\_\_

RECEIVED



08926

## CERTIFICATE OF DEATH

Reg. Dist. No.

08950

302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>24 Hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X / Clear Spring R # 1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>				d. STREET ADDRESS <b>Rockdale</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>EYSTER</b> Last <b>ROWE</b>				4. DATE OF DEATH Month <b>August</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24 1881</b>		9. AGE (In years lost birthday) yrs. <b>76</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md. Myersville Fred Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Josiah Rowe</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Ambrose</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-20-2877</b>		17. INFORMANT Address <b>Mrs Barbara A. Rowe Greencastle Pa R # 2 Box 224 % Russell C. Rowe</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis with Cavitation</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X Diabetes Mellitus</b>				INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 16, 1957</b> to <b>August 18, 1957</b> , that I last saw the deceased alive on <b>August 18, 1957</b> and that death occurred at <b>10:30 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Archie Robert Cohen</b> M.D.				PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D. Clear Spring, Maryland Aug. 19, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/20/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Church of Bretheren Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Broadfording Wash. Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>Aug 21 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Blair Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

AUG 23 1957

RECEIVED

08927

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Antrim 75x-3</u>	
c. LENGTH OF STAY IN 1b <u>2 Days</u>		d. STREET ADDRESS <u>RD3 - Greencastle</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>F.</u> Middle <u>SHAFER</u> Last		4. DATE OF DEATH <u>August 29</u> Month <u>29</u> Day <u>1957</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 16, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (State or foreign country) <u>Mercersburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Simon Shaffer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Miesinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>205-09-6883</u>	
17. INFORMANT <u>Clyde Shaffer</u> Address <u>RD3 Waynesboro, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Anterior - Septate Heart Dis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 Congestive Failure -</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u> <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>27 Aug 1957</u> to <u>29 Aug 1957</u> that I last saw the deceased alive on <u>29 Aug 1957</u> , and that death occurred at <u>8:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul F. Webster</u> M.D.		ADDRESS (Street, city or town, State) <u>Greencastle, Pa.</u> DATE SIGNED <u>30 Aug 57</u>	
PHYSICIAN'S NAME (Type) <u>Paul F. Webster, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9/1/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Welsh Run Brethren</u>	22d. LOCATION (City, town, or county) (State) <u>Welsh Run, Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich</u> ADDRESS <u>Greencastle Pa.</u>		24. REC'D BY REGISTRAR <u>Sept. 3. 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Elizabeth Powers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARITAL STATUS		PREVIOUS ILLNESS	
SIGNS AND SYMPTOMS		TREATMENT	
HISTORY		PATHOLOGICAL FINDINGS	
LABORATORY TESTS		POST-MORTEM EXAMINATION	
FAMILY HISTORY		SOCIAL HISTORY	
MEDICAL HISTORY		SURGICAL HISTORY	
DENTAL HISTORY		PSYCHIATRIC HISTORY	
PHYSICAL EXAMINATION		NEUROLOGICAL EXAMINATION	
VITAL SIGNS		LABORATORY TESTS	
X-RAY EXAMINATION		PATHOLOGICAL FINDINGS	
HISTOPATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
IMMUNOLOGICAL FINDINGS		BACTERIOLOGICAL FINDINGS	
VIROLOGICAL FINDINGS		PARASITOLOGICAL FINDINGS	
CYTOLOGICAL FINDINGS		HAEMATOLOGICAL FINDINGS	
URINALYSIS		BLOOD CHEMISTRY	
ECG		X-RAY	
PHYSIOLOGICAL TESTS		PSYCHOLOGICAL TESTS	
SOCIAL HISTORY		FAMILY HISTORY	
MEDICAL HISTORY		SURGICAL HISTORY	
DENTAL HISTORY		PSYCHIATRIC HISTORY	
PHYSICAL EXAMINATION		NEUROLOGICAL EXAMINATION	
VITAL SIGNS		LABORATORY TESTS	
X-RAY EXAMINATION		PATHOLOGICAL FINDINGS	
HISTOPATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
IMMUNOLOGICAL FINDINGS		BACTERIOLOGICAL FINDINGS	
VIROLOGICAL FINDINGS		PARASITOLOGICAL FINDINGS	
CYTOLOGICAL FINDINGS		HAEMATOLOGICAL FINDINGS	
URINALYSIS		BLOOD CHEMISTRY	
ECG		X-RAY	
PHYSIOLOGICAL TESTS		PSYCHOLOGICAL TESTS	

BUREAU V. S.

SEP 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
CERTIFICATE OF DEATH									
08928					08952 202				
Item 18: Replacement 8/29/57 G219-L					Reg. Dist. No.				
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna</b> b. COUNTY <b>Franklin</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>2 Weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mercersburg</b> <b>75x-3</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>					d. STREET ADDRESS <b>117 East Seminary St</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY BEAR SHANK</b>					4. DATE OF DEATH Month <b>Aug</b> Day <b>19</b> Year <b>1957</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan 16 1905</b>		9. AGE (In years last birthday) yrs. <b>52</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md. Hagerstown Wash. Co</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Martin N. Bear</b>					14. MOTHER'S MAIDEN NAME <b>Lillie Miller</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>186-09-5206</b>		17. INFORMANT <b>Martin I. Shank 117 E. Seminary Ave</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>198x Retroposterior lymphosarcoma</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <b>8/14, 1957</b> , to <b>8/19, 1957</b> , that I last saw the deceased alive on <b>8/18, 1957</b> , and that death occurred at <b>6:40 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>John H. Hornbaker, M.D.</b> <b>154 West Washington St.,</b> <b>8:19:57</b> PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b> <b>Hagerstown, Md.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/31/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Church of Brethren Cem. Broadfording Wash. Co Md</b>			22d. LOCATION (City, town, or county) _____ (State) _____		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>					24a. RECEIVED BY REGISTRAR <b>Aug 29 1957</b> DATE _____ 24b. REGISTRAR'S SIGNATURE <b>Chas. Beverly</b>				



CERTIFICATE OF DEATH

8008

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES EARL RAY		MALE		35		MAY 19 1928	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
MEMPHIS, TENN.		ATTORNEY		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE	
APRIL 4 1968		MEMPHIS, TENN.		4:00 PM		100.0	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		DATE	
[Signature]		[Signature]		[Signature]		APR 4 1968	
NAME OF PHYSICIAN		NAME OF REGISTRAR		NAME OF WITNESS		ADDRESS	
DR. J. H. [Name]		[Name]		[Name]		[Address]	

BUREAU V. 3

AUG 29 1957

RECEIVED

Andrew K. Collins Hagerstown Md.

08929

CERTIFICATE OF DEATH

Reg. Dist. No.

08953  
302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>4 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlock Conv. Home</b>				d. STREET ADDRESS <b>No Street Address</b>			
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>D.</b> Last <b>Shatzer</b>				4. DATE OF DEATH Month <b>8</b> Day <b>5</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-15-1879</b>	
9. AGE (In years last birthday) <b>78 yrs.</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>21</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>St. Thomas, Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>George W. Diffenderfer</b>				14. MOTHER'S MAIDEN NAME <b>Larue Shetron</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. C. Melvin Shields, St. Thomas, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>491X</b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mentally Ill</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Hour <b></b> Month <b></b> Day <b>19</b> Year <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) <b>-</b> (County) <b>-</b> (State) <b>-</b>	
21. I certify that I attended the deceased from <b>March 19, 1957</b> , to <b>August 5, 1957</b> , that I last saw the deceased alive on <b>August 5, 1957</b> , and that death occurred at <b>10:00 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. Robert Wells</b> M.D.				ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b>		DATE SIGNED <b>8-7-57</b>	
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>				Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-9-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>St. Thomas, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. Franklin Royer</b> ADDRESS <b>Hagerstown, Maryland</b>				24a. REC'D BY REGISTRAR <b>Aug. 9, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Blair H. Bowers</b>	

CERTIFICATE OF DEATH

02222

DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY	
COUNTY		STATE	
AGE		SEX	
MARRIED		OCCUPATION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER	
SIGNATURE OF CORONER		SIGNATURE OF JURY	
SIGNATURE OF DEPUTY COMMISSIONER		SIGNATURE OF CLERK	

BUREAU V. 1

AUG 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08954

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>339 Elizabeth Avenue</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Atlee</b> Middle <b>Barkdoll</b> Last <b>Sheiss</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>30</b> Year <b>19 57</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28, 1916</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furniture Assembler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own</b>		
11. BIRTHPLACE (State or foreign country) <b>Ringgold Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Barry G. Sheiss</b>		14. MOTHER'S MAIDEN NAME <b>Leah Barkdoll</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-01-4055</b>		
17. INFORMANT <b>Ruth Rhines Sheiss, 339 Elizabeth Ave.,</b>		Address <b>Hagerstown Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun Shot wound into head - 22 calibre</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>976x</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in head with 22 calibre</b>		
20c. TIME OF INJURY Month, Day, Year <b>Aug. 30 19 57</b> Hour <b>8:30</b> P. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Hagerstown</b> (County) <b>Wash</b> (State) <b>Md</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/2/57</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Ringgold</b>		22d. LOCATION (City, town, or county) <b>Ringgold, Washington Md.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter J. Grove, Waplesboro Pa</b>		24a. REC'D BY REGISTRAR <b>SEP 3 1957</b>		
		24b. REGISTRAR'S SIGNATURE <b>Chas. Powers</b>		

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12280

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		45		JAN 15 1912	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE	
JAN 20 1957		HOME		10:30 AM		98.6	
SIGNATURE OF EXAMINER		TITLE		DATE		TIME	
J. H. HARRIS		LABORER		JAN 20 1957		10:30 AM	
SIGNATURE OF WITNESSES		TITLE		DATE		TIME	
J. H. HARRIS		LABORER		JAN 20 1957		10:30 AM	
SIGNATURE OF CORONER		TITLE		DATE		TIME	
J. H. HARRIS		LABORER		JAN 20 1957		10:30 AM	
SIGNATURE OF JURY		TITLE		DATE		TIME	
J. H. HARRIS		LABORER		JAN 20 1957		10:30 AM	

BUREAU V. 2

3 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
08931					MEDICAL EXAMINER'S CERTIFICATE OF DEATH				
Reg. Dist. No. 08955 303									
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			c. LENGTH OF STAY IN 1b <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>					d. STREET ADDRESS <b>/ REAR 399 LIBERTY ST.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>WILLIAM</b> Last <b>SMITH</b>					4. DATE OF DEATH Month <b>AUGUST</b> Day <b>13</b> Year <b>19 57</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/31/1910</b>		9. AGE (In years last birthday) <b>46 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>JANITOR WORK</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES E. SMITH</b>					14. MOTHER'S MAIDEN NAME <b>BESSIE BAKER</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-09-9635</b>		17. INFORMANT <b>MR. CECIL SMITH</b>		Address <b>HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 DUE TO Acute coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b> INTERVAL BETWEEN ONSET AND DEATH _____									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <b>None</b>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) <b>-</b>		(County) <b>-</b> (State) <b>-</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>S. Robert Wells</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Type) <b>BURIAL</b>					22b. DATE THEREOF <b>8/15/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FAHRNEY CHURCH CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON COUNTY MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Horment, Hagerstown Ind.</b>					ADDRESS <b>Hagerstown Ind.</b>		24a. REC'D BY REGISTRAR <b>Aug. 16 - 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Robert Bowers</b>

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		AGE 35		SEX MALE		RACE WHITE		DATE OF DEATH JUNE 28, 1968		PLACE OF DEATH WASHINGTON COUNTY HOSPITAL	
MANNER OF DEATH Suicide		CAUSE OF DEATH FIREARM WOUND		SITE OF DEATH Chest		NATURE OF DEATH Suicide		DATE OF EXAMINATION JULY 1, 1968		PLACE OF EXAMINATION WASHINGTON COUNTY HOSPITAL	
FATHER'S NAME JAMES EARL RAY		MOTHER'S NAME JANE RAY		BIRTH DATE JULY 1, 1933		BIRTH PLACE MEMPHIS, TENN.		EDUCATION High School		OCCUPATION None	
PREVIOUS MARRIAGES None		MARRIAGE DATE None		MARRIAGE PLACE None		MARRIAGE TYPE None		MARRIAGE DURATION None		MARRIAGE STATUS None	
PREVIOUS DEATHS None		DEATH DATE None		DEATH PLACE None		DEATH TYPE None		DEATH DURATION None		DEATH STATUS None	
PREVIOUS INMATE None		INMATE DATE None		INMATE PLACE None		INMATE TYPE None		INMATE DURATION None		INMATE STATUS None	
PREVIOUS ARRESTS None		ARREST DATE None		ARREST PLACE None		ARREST TYPE None		ARREST DURATION None		ARREST STATUS None	
PREVIOUS CONVICTIONS None		CONVICTION DATE None		CONVICTION PLACE None		CONVICTION TYPE None		CONVICTION DURATION None		CONVICTION STATUS None	
PREVIOUS SENTENCES None		SENTENCE DATE None		SENTENCE PLACE None		SENTENCE TYPE None		SENTENCE DURATION None		SENTENCE STATUS None	
PREVIOUS DEPORTATIONS None		DEPORTATION DATE None		DEPORTATION PLACE None		DEPORTATION TYPE None		DEPORTATION DURATION None		DEPORTATION STATUS None	
PREVIOUS RE-ENTRY None		RE-ENTRY DATE None		RE-ENTRY PLACE None		RE-ENTRY TYPE None		RE-ENTRY DURATION None		RE-ENTRY STATUS None	
PREVIOUS DEPORTATIONS None		DEPORTATION DATE None		DEPORTATION PLACE None		DEPORTATION TYPE None		DEPORTATION DURATION None		DEPORTATION STATUS None	
PREVIOUS RE-ENTRY None		RE-ENTRY DATE None		RE-ENTRY PLACE None		RE-ENTRY TYPE None		RE-ENTRY DURATION None		RE-ENTRY STATUS None	

RECEIVED  
AUG 19 1968  
BUREAU V. S.

08932

## CERTIFICATE OF DEATH

08956

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Security</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Martin Manor Rest Home</b>				d. STREET ADDRESS <b>33 Green Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>THOMAS</b> First <b>HAYS</b> Middle <b>SMITH</b> Last				4. DATE OF DEATH Month <b>August</b> Day <b>8</b> Year <b>1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1876</b>		9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>13</b>	IF UNDER 24 HRS. Hours <b>13</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Blacksmith</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Panama Canal Zone</b>		11. BIRTHPLACE (State or foreign country) <b>Woodbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Henry Smith</b>				14. MOTHER'S MAIDEN NAME <b>Liza Noonon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-10-6892</b>		17. INFORMANT <b>Mrs. Emma J. Smith Security, Maryland</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b> <b>334x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease--2 years</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>August 7, 1957</b> , to <b>August 8, 1957</b> , that I last saw the deceased alive on <b>August 7, 1957</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <b>W. T. Layman, M.D.</b>				M.D. <b>100 Professional Arts Bldg. 8-9-57</b>			
PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>				<b>Hagerstown Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/11/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suterhouser Funeral Home</b> <b>R. Franklin Ruzer</b>				ADDRESS <b>Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR <b>Aug. 13, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Shash Powers</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of medical examiner		12. Signature of health officer	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of burial place		18. Signature of burial place		19. Signature of burial place		20. Signature of burial place	
21. Signature of burial place		22. Signature of burial place		23. Signature of burial place		24. Signature of burial place	
25. Signature of burial place		26. Signature of burial place		27. Signature of burial place		28. Signature of burial place	
29. Signature of burial place		30. Signature of burial place		31. Signature of burial place		32. Signature of burial place	
33. Signature of burial place		34. Signature of burial place		35. Signature of burial place		36. Signature of burial place	
37. Signature of burial place		38. Signature of burial place		39. Signature of burial place		40. Signature of burial place	
41. Signature of burial place		42. Signature of burial place		43. Signature of burial place		44. Signature of burial place	
45. Signature of burial place		46. Signature of burial place		47. Signature of burial place		48. Signature of burial place	
49. Signature of burial place		50. Signature of burial place		51. Signature of burial place		52. Signature of burial place	
53. Signature of burial place		54. Signature of burial place		55. Signature of burial place		56. Signature of burial place	
57. Signature of burial place		58. Signature of burial place		59. Signature of burial place		60. Signature of burial place	
61. Signature of burial place		62. Signature of burial place		63. Signature of burial place		64. Signature of burial place	
65. Signature of burial place		66. Signature of burial place		67. Signature of burial place		68. Signature of burial place	
69. Signature of burial place		70. Signature of burial place		71. Signature of burial place		72. Signature of burial place	
73. Signature of burial place		74. Signature of burial place		75. Signature of burial place		76. Signature of burial place	
77. Signature of burial place		78. Signature of burial place		79. Signature of burial place		80. Signature of burial place	
81. Signature of burial place		82. Signature of burial place		83. Signature of burial place		84. Signature of burial place	
85. Signature of burial place		86. Signature of burial place		87. Signature of burial place		88. Signature of burial place	
89. Signature of burial place		90. Signature of burial place		91. Signature of burial place		92. Signature of burial place	
93. Signature of burial place		94. Signature of burial place		95. Signature of burial place		96. Signature of burial place	
97. Signature of burial place		98. Signature of burial place		99. Signature of burial place		100. Signature of burial place	

RECEIVED  
AUG 15 1957  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08925

## CERTIFICATE OF DEATH

08957

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>13 Yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>412 Summit Ave</b>				e. STREET ADDRESS <b>412 Summit Ave</b>			
3. NAME OF DECEASED (Type or print) First <b>FLORA</b> Middle <b>ELIZABETH</b> Last <b>SNOOK</b>				4. DATE OF DEATH Month <b>August</b> Day <b>29</b> Year <b>1957</b> 19			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 25 1886</b>	9. AGE (In years last birthday) <b>71</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md. Tilghmanton Wash. Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William Turner</b>				14. MOTHER'S MAIDEN NAME <b>Harriett Ridenour</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-8466</b>		17. INFORMANT <b>Samuel E. Snook 412 Summit Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Acute coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Five minutes</b> <b>About 3 1/2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept. 14, 1959</b> , to <b>Aug 29, 1957</b> , that I last saw the deceased alive on <b>7/5, 1957</b> , and that death occurred at <b>11:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>154 West Washington St., Hagerstown, Md.</b> DATE SIGNED <b>8:30:57</b>							
ACTUAL SIGNATURE <b>John H. Hornbaker</b>				M.D. <b>154 West Washington St., Hagerstown, Md.</b>			
PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>				<b>Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>9/1/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Sept. 2, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Shasth...</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD. CERTIFICATE OF DEATH

BUREAU V. S.

SEP 4 1957

RECEIVED

08933

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 242 S. Potomac St.				d. STREET ADDRESS 1 242 S. Potomac St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Roy Thomas Staubs				4. DATE OF DEATH Month Aug. 29, Day 19, Year 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 2, 1880	
9. AGE (In years last birthday) 77		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk				10b. KIND OF BUSINESS OR INDUSTRY tavern		11. BIRTHPLACE (State or foreign country) Sharpsburg, Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Frisby Staubs				14. MOTHER'S MAIDEN NAME Arrabella Grey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 216-14-5165		17. INFORMANT Mrs. Irene G. Mowen, Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 6 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8/18/52, 19, to 8/29, 1957, that I last saw the deceased alive on 7/30, 1957, and that death occurred at 11:35 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE George Jennings M.D. 1364 W. Washington St.				8/30/57			
PHYSICIAN'S NAME (Type) George Jennings, M.D. Hagerstown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8-31-57		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				24a. RECEIVED BY REGISTRAR Sept. 3, 1957		24b. REGISTRAR'S SIGNATURE B. H. Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "Maryland"]		DATE OF BIRTH [Faint text, possibly "1912"]		PLACE OF DEATH [Faint text, possibly "Baltimore"]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "September 5, 1957"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF INTERMENT [Faint text, possibly "Catholic Cemetery"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
CERTIFICATE NO. [Faint text, possibly "12345"]		COUNTY [Faint text, possibly "Baltimore"]		STATE [Faint text, possibly "Maryland"]	

BUREAU V. 5

SEP 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, & 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08959

08934

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>85 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>36 S. POTOMAC ST.</b>		e. STREET ADDRESS <b>36 S. POTOMAC ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>LIZZIE</b> Middle Last <b>STAUFFER</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>3</b> Year <b>19 57</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/18/1866</b>
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH T. HOFFMAN</b>		14. MOTHER'S MAIDEN NAME <b>MARY McCAULEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR. ALVIN P. STAUFFER</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Brain Syndrome</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1</b> , 19 <b>57</b> , to <b>Aug. 3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Aug. 2</b> , 19 <b>57</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>170 W. Washington St</b> DATE SIGNED <b>8/5/57</b> ACTUAL SIGNATURE <b>R. S. Stauffer</b> M.D. PHYSICIAN'S NAME (Type) <b>R. S. Stauffer</b> <b>Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8/6/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment</b>		24. REC'D BY REGISTRAR <b>Aug. 7, 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. Norment</b>		24c. REGISTRAR'S SIGNATURE <b>W. J. Norment</b>	

# CERTIFICATE OF DEATH

<p>NAME OF DECEASED  <b>WASHINGTON</b></p>		<p>DATE OF BIRTH  <b>1911</b></p>	
<p>PLACE OF BIRTH  <b>WASHINGTON</b></p>		<p>AGE  <b>44 YRS.</b></p>	
<p>DATE OF DEATH  <b>25 6 1957</b></p>		<p>PLACE OF DEATH  <b>POTOMAC ST.</b></p>	
<p>TIME OF DEATH  <b>11:00 AM</b></p>		<p>CAUSE OF DEATH  <b>HEART DISEASE</b></p>	
<p>SEX  <b>MALE</b></p>		<p>EDUCATION  <b>GRADUATE</b></p>	
<p>RELIGION  <b>PROTESTANT</b></p>		<p>US CITIZENSHIP  <b>U.S.A.</b></p>	
<p>NAME OF DECEASED  <b>JOSEPH T. HOFFMAN</b></p>		<p>DATE OF BIRTH  <b>1911</b></p>	
<p>PLACE OF BIRTH  <b>WASHINGTON</b></p>		<p>AGE  <b>44 YRS.</b></p>	
<p>DATE OF DEATH  <b>25 6 1957</b></p>		<p>PLACE OF DEATH  <b>POTOMAC ST.</b></p>	
<p>TIME OF DEATH  <b>11:00 AM</b></p>		<p>CAUSE OF DEATH  <b>HEART DISEASE</b></p>	
<p>SEX  <b>MALE</b></p>		<p>EDUCATION  <b>GRADUATE</b></p>	
<p>RELIGION  <b>PROTESTANT</b></p>		<p>US CITIZENSHIP  <b>U.S.A.</b></p>	
<p>NAME OF DECEASED  <b>WASHINGTON</b></p>		<p>DATE OF BIRTH  <b>1911</b></p>	
<p>PLACE OF BIRTH  <b>WASHINGTON</b></p>		<p>AGE  <b>44 YRS.</b></p>	
<p>DATE OF DEATH  <b>25 6 1957</b></p>		<p>PLACE OF DEATH  <b>POTOMAC ST.</b></p>	
<p>TIME OF DEATH  <b>11:00 AM</b></p>		<p>CAUSE OF DEATH  <b>HEART DISEASE</b></p>	
<p>SEX  <b>MALE</b></p>		<p>EDUCATION  <b>GRADUATE</b></p>	
<p>RELIGION  <b>PROTESTANT</b></p>		<p>US CITIZENSHIP  <b>U.S.A.</b></p>	

BUREAU V. R.

AUG 9 1957

RECEIVED



08935

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>16 1/2 Hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X / Big Spring</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>				d. STREET ADDRESS <b>1 Dam # 5 Rd</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WALTER</b>		First Middle Last <b>JAMES TIMBERMAN</b>		4. DATE OF DEATH Month Day Year <b>August 27 1957 19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 4 1907</b>	9. AGE (In years last birthday) <b>49</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dupont Co</b>		11. BIRTHPLACE (State or foreign country) <b>York York Co Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Parke Timberman</b>				14. MOTHER'S MAIDEN NAME <b>Janet woodside</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W.# 2</b>		16. SOCIAL SECURITY NO. <b>147-03-1187</b>		17. INFORMANT Address <b>Mary E. Timberman Big Spring Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>163X</b> DUE TO <b>Reticulum cell sarcoma of the right lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>1 year.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 15</b> , 19 <b>57</b> , to <b>Aug. 27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Aug. 26</b> , 19 <b>57</b> , and that death occurred at <b>12:40am</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Archie Robert Cohen</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D. Clear Spring, Md. Aug. 27, 1957</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/31/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Salem Baptist Cemetery Salem</b>		22d. LOCATION (City, town, or county) (State) <b>Salem Co N. Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>Aug 29 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Walter H. Bowers</b>	

# CERTIFICATE OF DEATH

<p>1. Name of deceased: <b>JAMES T. BROWN</b></p>		<p>2. Sex: <b>Male</b></p>	
<p>3. Date of birth: <b>Jan 15 1900</b></p>		<p>4. Place of birth: <b>St. Louis, Mo.</b></p>	
<p>5. Date of death: <b>Aug 10 1957</b></p>		<p>6. Place of death: <b>St. Louis, Mo.</b></p>	
<p>7. Cause of death: <b>Heart Disease</b></p>		<p>8. Manner of death: <b>Natural</b></p>	
<p>9. Signature of physician: <b>Dr. J. H. Smith</b></p>		<p>10. Signature of registrar: <b>John Doe</b></p>	

BUREAU V. S.

SEP 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 only should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08936

## CERTIFICATE OF DEATH

08961

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Maryland</u>				c. LENGTH OF STAY IN 1b <u>45 yrs.</u>			
d. USUAL OCCUPATION (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Theodore (ne) Timbers</u>				4. DATE OF DEATH Month Day Year <u>Aug 8 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec-16 1905</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Private family</u>		11. BIRTHPLACE (State or foreign country) <u>Lovettsville Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>Joseph Timbers</u>				14. MOTHER'S MAIDEN NAME <u>Lea Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Gertrude William Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epithelial carcinoma esophagus</u> <u>150x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> (history)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>028. Lues, late latent</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 4</u> , 19 <u>57</u> , to <u>August 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>August 7</u> , 19 <u>57</u> , and that death occurred at <u>7:15 A</u> .M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>W. J. Layman, M.D.</u> M.D. <u>100 Professional Arts Bldg. 8-9-57</u> PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u> <u>Hagerstown</u> <u>Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 10 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R Watson Jr. Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>Aug 10 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Blair H. Bowers</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
JAMES H. WATSON		45		M		W		JAN 15 1912		BALTIMORE, MD		AUG 13 1957		BALTIMORE, MD	
MARRIAGE		DATE		PLACE		NAME		DATE		PLACE		NAME		DATE	
MARRIED		JAN 15 1935		BALTIMORE, MD		JAMES H. WATSON		JAN 15 1935		BALTIMORE, MD		JAMES H. WATSON		JAN 15 1935	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		POLITICAL PARTY		SOCIETY		OTHER	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		DEMOCRAT		BALTIMORE		NONE	
SIGNATURE OF PHYSICIAN		DATE		SIGNATURE OF CORONER		DATE		SIGNATURE OF REGISTRAR		DATE		SIGNATURE OF DECEASED		DATE	
JAMES H. WATSON		AUG 13 1957		JAMES H. WATSON		AUG 13 1957		JAMES H. WATSON		AUG 13 1957		JAMES H. WATSON		AUG 13 1957	

BUREAU V. S.

AUG 13 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

08937

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08962  
302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	c. LENGTH OF STAY IN 1b <b>2 weeks</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport Md RFD 1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>Pinesburg</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Mammie</b> Middle <b>Mae</b> Last <b>Timmons</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>30</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 18, 1935</b>
9. AGE (In years last birthday) <b>21</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>12</b>	IF UNDER 24 HRS. Hours <b>12</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Dennis Grams</b>		14. MOTHER'S MAIDEN NAME <b>Mrs. Mammie Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-30-6153</b>	
17. INFORMANT <b>Mr. Leroy D Timmons</b>		Address <b>Williamsport Md RFD1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured(open) rt. tibia</b> 825X DUE TO <b>Fractured ribs</b> Conditions, if any, which gave rise to immediate cause (b) <b>Pulmonary emboli (acute)</b> (a), stating the underlying cause lost. DUE TO <b>Delayed hemorrhage into spleen</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b> <b>14 days</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto accident</b>	
20c. TIME OF INJURY Hour <b>10:30</b> AM <b>Aug. 16 '57</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	20f. (City or town) (County) (State) <b>Hagerstown Wash Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		DATE SIGNED <b>Aug. 31 '57</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 1-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Williamsport Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Wolf Williamsport, Md</b>		24a. REC'D BY REGISTRAR <b>Aug 31, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Chas H Bowers</b>



3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE, 18

08938

## CERTIFICATE OF DEATH

08963

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 03	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. county Hospital</u>		d. STREET ADDRESS <u>303 Bryan Place</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET CAROLINE WARNER</u>		4. DATE OF DEATH Month Day Year <u>August 24 1957</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27 1895</u> 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Md</u>
13. FATHER'S NAME <u>William Klipp</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Angle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Harry B. Warner Sr</u> Address <u>303 Bryan Place</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Recto-Sigmoid</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 27, 1957</u> , to <u>Aug 24, 1957</u> , that I last saw the deceased alive on <u>Aug 24, 1957</u> , and that death occurred at <u>11:12 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert P. Conrad</u>		ADDRESS (Street, city or town, state) <u>Hagerstown, Md</u>	
PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>		DATE SIGNED <u>8-26-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/27/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>
22d. LOCATION (City, town, or county) <u>Hagerstown Wash. Co Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Aug 28 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Robert H. Bowser</u>	



08939

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN TB <b>10 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>HAGERSTOWN MARYLAND ROUTE 1</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAUDE ECCARD WEAGLY</b>				4. DATE OF DEATH Month Day Year <b>AUGUST 16 1957 19</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 8 1886</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BEAVER CREEK WASH.CO.MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>NATHAN C. ECCARD</b>				14. MOTHER'S MAIDEN NAME <b>CHARLOTTE R. GAVER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>ROY C.F. WEAGLY HAGERSTOWN MD. ROUTE 1.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Histiosisclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with Coronary Insufficiency</b> DUE TO (c) <b>Chronic interstitial cystitis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2-3 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>Aug 15, 1957</b> to <b>Aug 16, 1957</b> , that I last saw the deceased alive on <b>Aug 16, 1957</b> , and that death occurred at <b>10:30</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edward W. Ditto II</b>		M.D. <b>212 W. Wash. Ave. SE</b>		ADDRESS (Street, city or town, state)		DATE SIGNED <b>8/16/57</b>	
PHYSICIAN'S NAME (Type) <b>Edward W. Ditto II, M.D.</b>		<b>Hagerstown, Md</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>AUG. 18 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BEAVER CREEK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BEAVER CREEK WASH.CO.MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE <b>Aug 22, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>East Hagerstown</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 22 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08965

08940

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>33 YRS.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>633 S. POTOMAC ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>NORMAN EVANS WEST SR.</b>				4. DATE OF DEATH Month Day Year <b>AUGUST 14 19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/1/1908</b>	
9. AGE (In years last birthday) <b>49 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHOP SUPT.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CONSRUCTION CO.</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>JOHN F. WEST</b>				14. MOTHER'S MAIDEN NAME <b>RUIE EVANS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-09-1152</b>		17. INFORMANT <b>MRS. EVELYN N. WEST</b> Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerosis of the coronary artery</b> <b>420.1</b> DUE TO <b>with occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Aug. 14</b> , 19 <b>57</b> , to <b>Aug. 14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Aug. 14</b> , 19 <b>57</b> , and that death occurred at <b>8:35 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>148 West Washington St. Hagerstown, Md.</b> DATE SIGNED <b>8/15/57</b> ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>[Signature]</b> PHYSICIAN'S NAME (Type) <b>Dr. B. B. Kneisley</b> <b>Hagerstown, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>8/16/57</b>		<b>REST HAVEN CEM.</b>		<b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Horment, Hagerstown, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>Aug. 16, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

RECEIVED

AUG 19 1957

BUREAU V. S.

TO HOSPITAL

may be 1

TO FUNERAL

page 3 should

the registrar

VS A15 (4)  
15M 9/55

R ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 ho  
d by the hospital or attending physician.

ECTOR: After this certificate has been signed by the attending physician and completely filled in  
be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or  
prior to burial, cremation, or removal, and in any event within 72 hours after death.

or death: Page 4

the funeral director.  
should be filed with

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08941

CERTIFICATE OF DEATH

Reg. Dist. No.

08966

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>10 X 1.2</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Josiah</b> Last <b>Wilhide</b>		4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-6-1903</b>
9. AGE (In years lost birthday) <b>53</b> yrs.		IF UNDER 1 YEAR: Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min. <b>53</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry W. Wilhide</b>		14. MOTHER'S MAIDEN NAME <b>Clara K. Damuth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-36-4852</b>	
17. INFORMANT <b>Mrs. Ruth B. Wilhide</b>		Address <b>Lantz, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized metastatic carcinoma.</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Primary carcinoma of stomach.</b> DUE TO (c) <b>4 mo.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/15</b> , 19 <b>57</b> , to <b>8/13</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>8/13</b> , 19 <b>57</b> , and that death occurred at <b>11:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Smithsburg, Maryland</b> DATE SIGNED <b>8/15/57</b> ACTUAL SIGNATURE <b>Charles F. Hess</b> M.D. PHYSICIAN'S NAME (Type) <b>Charles F. Hess</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-16-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>United Brethren Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Maryland</b>	
24. REC'D BY REGISTRAR <b>Aug 18 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. A. Lowrey</b>	

MEDICAL CERTIFICATION

**BUREAU V. 8**

AUG 16 1957

RECEIVED